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References: 1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: **Brit. M. J.** 2:606, Oct. 3, 1959. **2.** Medrek, T. F., and Litsky, W.: **Surg. Gynec. & Obst.** (Internat. Abstr. Surg.) 104:209, March, 1957. **3.** Prazak, George; Ferguson, J. A.; Comer, J. E., and McNeill, Betty S.: **J. South Carolina M. A.** 56:23 (Abstr.), Jan., 1960. **4.** Hendler, S. S.: **J. Nat. A. Chirop.** 44:57, June, 1954. **5.** Ashur, M. E., and Guild, B. T.: **J. Nat. A. Chirop.** 44:19, June, 1954. **6.** Hodges, F. T.: **GP** 14:86, Nov., 1956.

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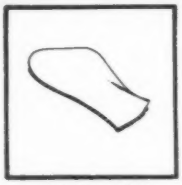

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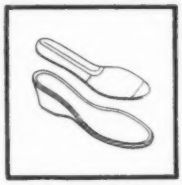

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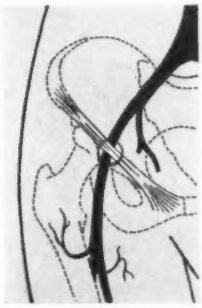

Site of femoral bruit over inguinal ligament.

Site of popliteal bruit popliteal fossa.

Performance of the Test

Auscultate for bruit in the femoral triangle over the inguinal ligament, in the popliteal space, or over the axillary or brachial artery. *If a bruit is present, its duration in relation to the cardiac cycle is the significant finding.* If no bruit is heard when the patient is at rest, he should be exercised by running in place for a few minutes, or until he complains of claudication. Auscultation of the areas is then repeated, and the presence and timing of any bruits again noted.

Interpretation of the Test

Continuous bruit, audible throughout both systole and diastole, indicates poor collateral circulation.

Systolic bruit, heard only during systole, which remains the same or decreases following exercise, indicates good collateral circulation. Bruit heard only in systole with patient at rest, but which becomes continuous following exercise, or increases in intensity, suggests that collateral circulation is minimal.

Early estimation of the collateral circulation permits a more complete diagnosis of the arterial insufficiency. Treatment can thus be more accurately individualized—improving likelihood of a favorable response to therapy.

*Murdaugh, H. V., Jr., and McIntosh, H. D.: New England J. Med. *259*:1170-1171 (Dec.) 1958.

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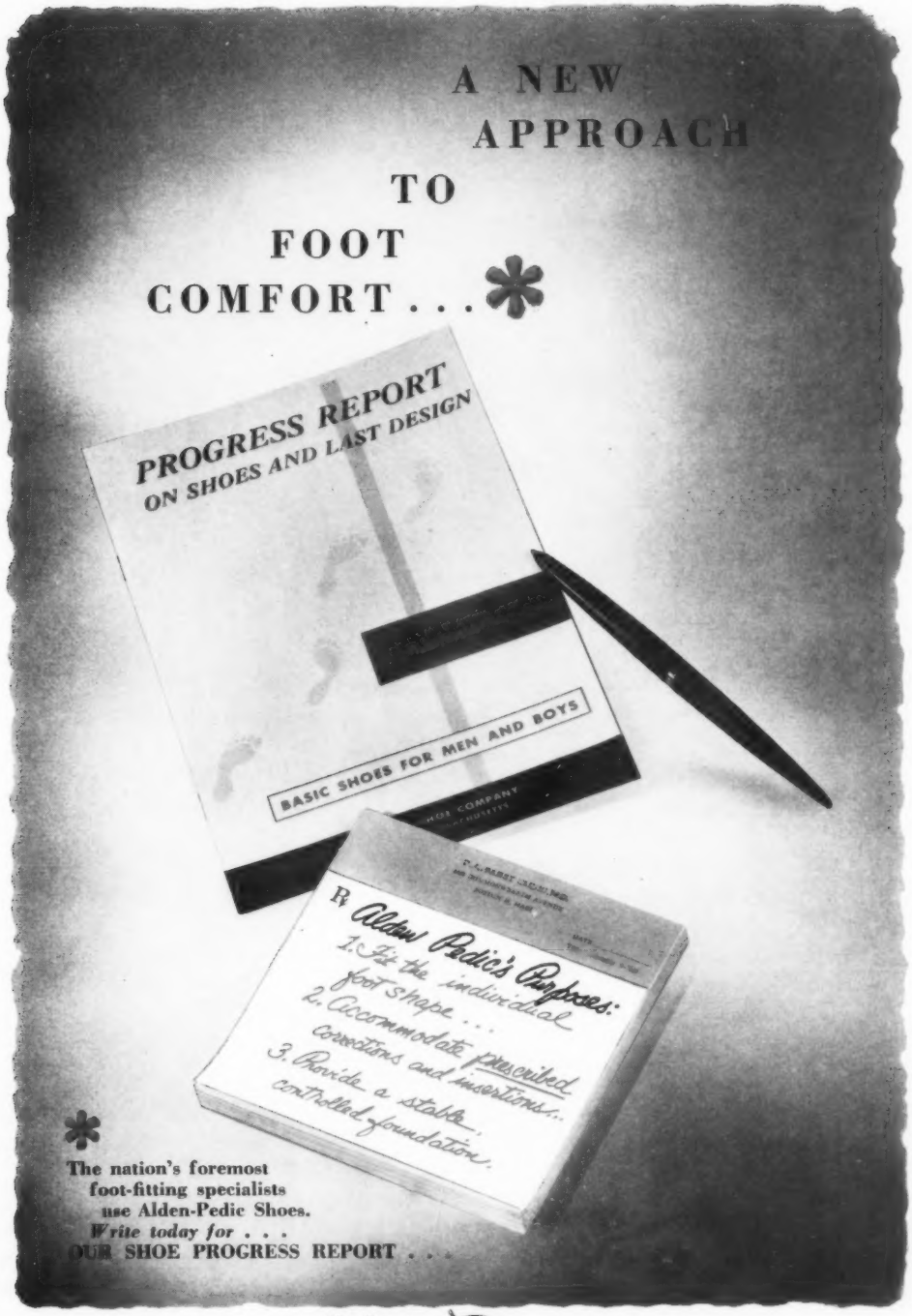
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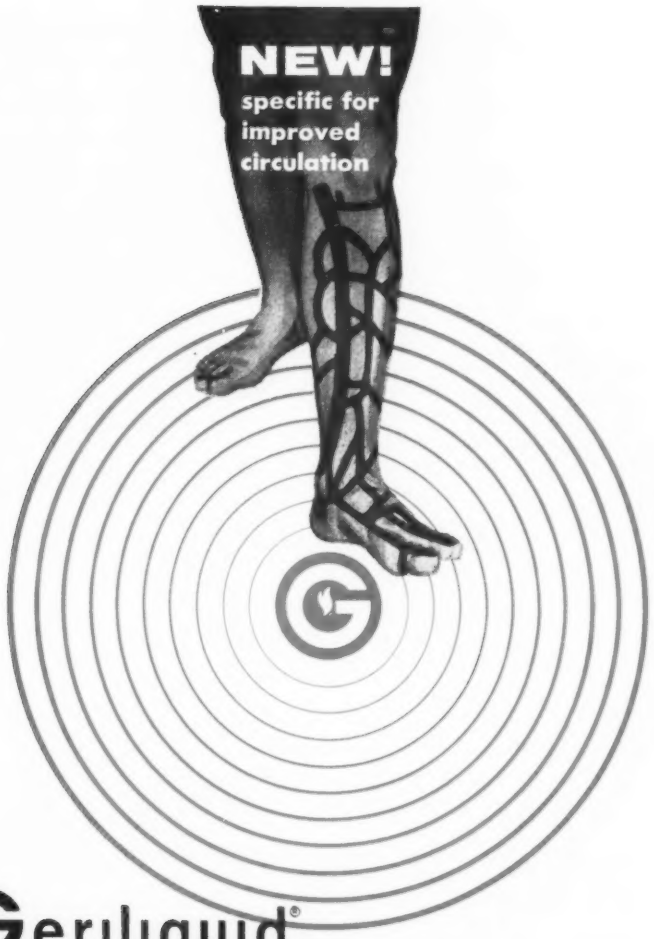

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Arizona

Arizona State Board of Chiropody Examiners. **Board Secretary:** Martin Snyder, D.S.C., 2629 E. Broadway, Tucson, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively Aug. 22-23, 1961 in Los Angeles; Oct. 17-18, 1961 in Sacramento. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento 15, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dover, Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Hawaii

The Hawaii Podiatry Board. **Board Secretary:** Dr. R. K. Lee, P.O. Box 3378, Honolulu, Hawaii.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Fredric B. Selke, Room 112, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 364 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville 7, Ky.

Louisiana

Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The Massachusetts Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. Charles H. Thorner, 910 Furnace Brook Parkway, Quincy, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Robert E. Ray, 512 N.W. Federal Bldg., Minneapolis, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody. **Board Secretary:** Frank Fulkerson, 611 Clay St., Chillicothe, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nev.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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*Combes, F. C.: Ind. Med. & Surg. 30:29-34 (Jan.) 1961

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References: (1) Sulzberger, M. B.; Wolf, J.; Witten, V. H., and Kopf, A. W.: Dermatology: Diagnosis and Treatment, ed. 2, Chicago, The Year Book Publishers, Inc., 1961, pp. 44-45. (2) Combes, F. C.: New York Physician & Am. Med. 33:3, 1949.

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State Board *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners. **Board Secretary:** Dr. Jack S. Pincus, 26 N. 3rd St., Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Podiatry Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Viola Marr, 115 N. Main Ave., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Tex.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Russell M. Cox, M.D., 509 Professional Bldg., Portsmouth, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

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*Walker, M. H., Rubefacient therapy for the feet, *Journal of the American Podiatry Association*, vol. 50, Oct. 1960.

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Nomenclature—Peter N. Varzos, 25 E. Washington St., Chicago, Ill.

Farm Foot Health—Ralph C. Kirkwood, Kresge Bldg., Des Moines, Iowa.

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Charles Turchin, 818 18th St., N. W., Washington, D. C.

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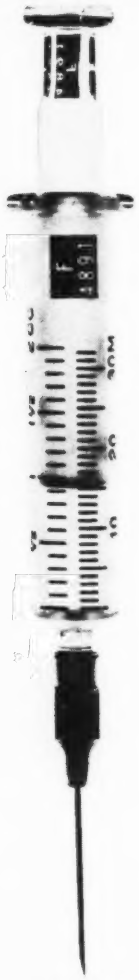

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References: 1. Sadove, M. S., and Wessinger, O. D.: **J. Internat. Coll. Surgeons** 34:573, Nov., 1960. **2.** Erickson, J. C., III, and Hricko. M. J.: **Guthrie Clin. Bull.** 29:45, 1959. **3.** Gordon, R. A.; Kerr, J. H., and Taylor, Russell: **Canada. Anaesth. Soc. J.** 7:290, July, 1960. **4.** Sadove, M. S.: **New Physician** 9:39, Sept., 1960. **5.** Young, J. A.: **Anesth. & Analg.** 39:451, Sept.-Oct., 1960.

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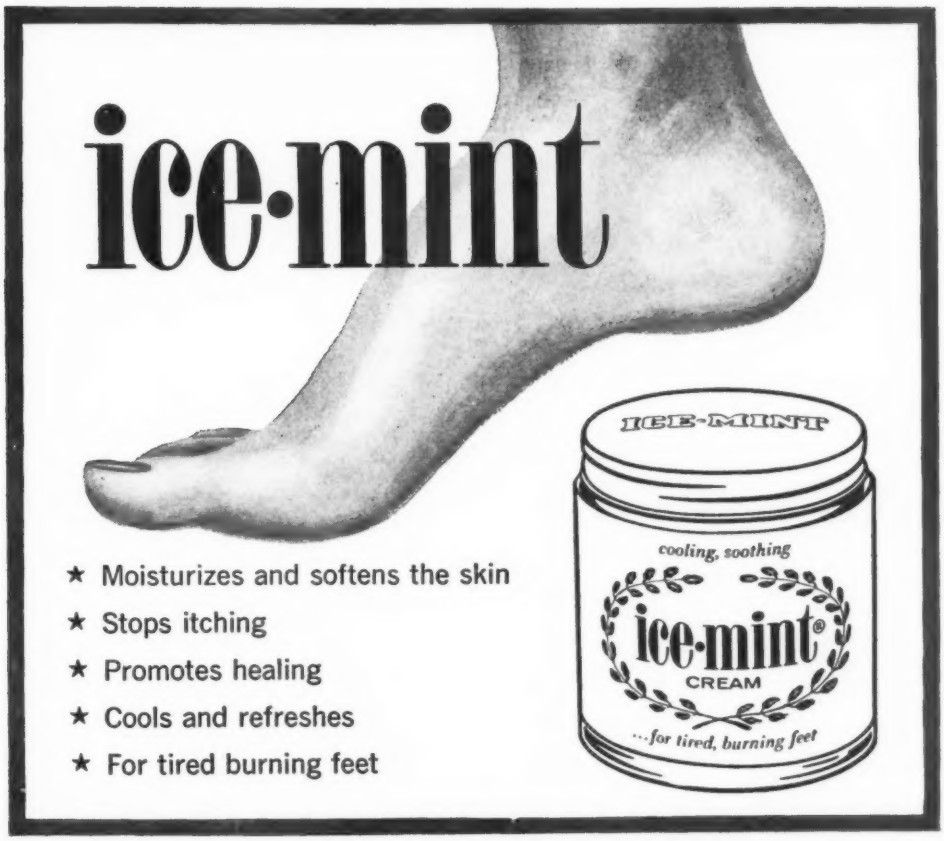

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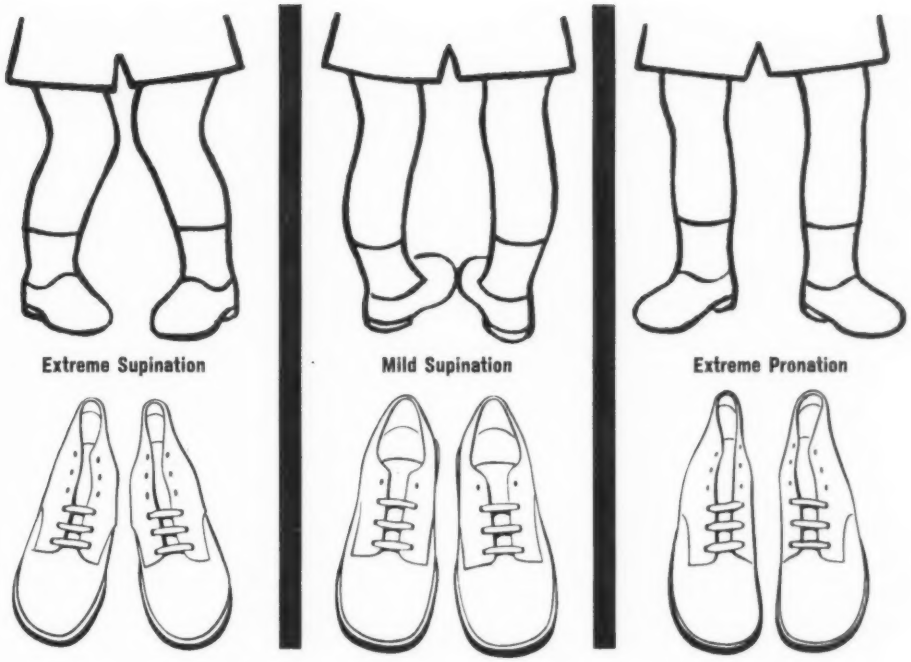

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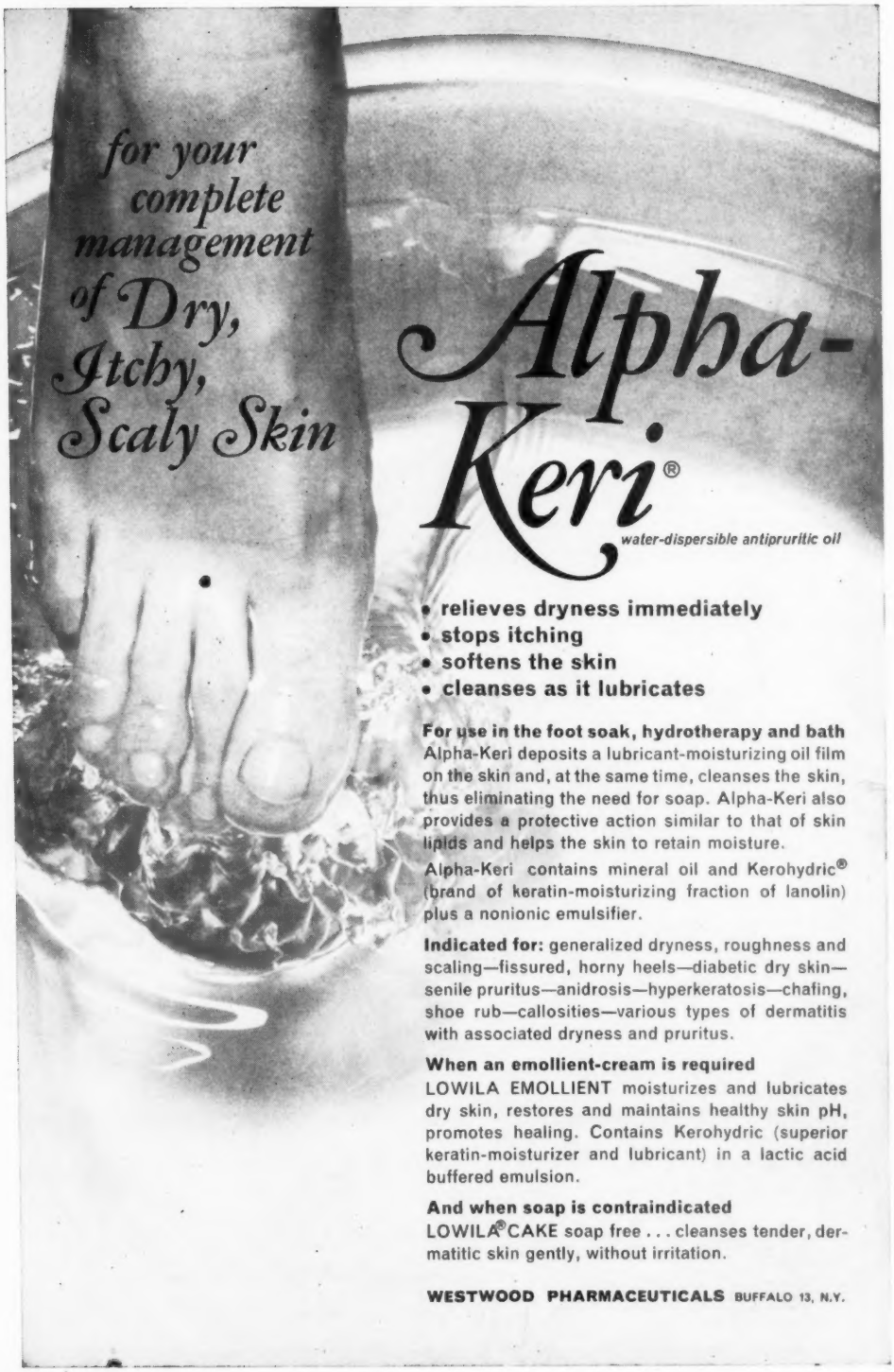
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Physiologic Rest Through Rigid Immobilization In the Treatment of Foot Problems

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The Podiatry Clinic at the USAF Hospital Andrews is part of the Orthopedic Service. Under this arrangement I work together with the orthopedist. Our clinic serves both the Airman and his family, thereby providing a moderate sampling of patient population. This paper expresses clinical impressions as seen in our clinic, comments and thoughts by Lt/Col. John A. Hennessen, USAF (MC), and the writings of Sir Reginald Watson Jones, M.D.

The increased use of so-called "flexible casting" has achieved some recognition in podiatric circles. I believe that this is a departure from fundamental principles of medicine and therefore compromises complete treatment for the patient's acceptance of less inconvenience. It shows poor understanding of bone and soft tissue repair.

The purpose of this paper is to focus attention on rigid immobilization, wrongly disregarded by some podiatrists because of improper emphasis at the training level. The principles of immobilization are well established in the treatment of frank uncomplicated fractures. However, there are those who believe that simple foot fractures left to their own resources will heal unattended. I shall touch on fractures specifically below. However, this paper is directed at soft tissue trauma, that with which we are most concerned in our daily practices. But the principles as applied to bone or soft tissue remain the same.

We have exhausted many therapeutic regimes to bring relief of pain and healing, while we have overlooked the benefits to be obtained from pure rigid immobilization in soft tissue wounds and infections. I emphasize four points:

1. Rigid immobilization can relieve pain completely.
2. Rigid immobilization prevents deforming contractures.
3. Rigid immobilization facilitates healing.
4. Rigid immobilization localizes infection.

Watson-Jones, the renowned British orthopedist, states, "Inflamed tissue, whether a wound of soft tissue or a fracture, is capable of dealing with its enemies unaided if kept at rest."[1]

If we can agree that inflamed tissue should be protected from any sudden or extreme motion that disrupts the orderly process of repair, we can go one step further and insist on the best method of protecting the inflamed tissue while permitting stress-free activity. Plaster serves our patients best by providing complete rest and comfort for the injured part while protecting against a reinjury. Complete immobility without proper care can be detrimental too, by perpetuating a vascular stasis to the uninjured structures and reducing or obliterating normal function. This factor has probably turned most podiatrists from rigid immobilization to "flexible casting." The ability to overcome this stasis and reduced function is attainable. When the blood supply is adequate, regardless of whether you are handling a compound fracture or an infected ulcer at the ball of the foot, the ideal treatment is a plaster cast which will insure complete rest. But the main criterion for selecting plaster immobilization must be that rigid immobilization will do more good than harm.

In our clinic we have treated numerous plantar infections by adequately incising the wound, removing all debris and necrotic tissue and then applying a plaster case over the sterile dressing. These wounds heal primarily with reduced morbidity. Trophic ulcers of neurogenic and diabetic etiology have been treated in this manner. All have been immobilized in plaster, thereby removing stress and insuring rest. There is immediate relief of pain and healing by first intention. Secondly, the plaster cast prevents capillary disruption caused by frequent debridement, foreign chemical agents used in cleansing, and by the doctor's hands putting organisms directly into the blood stream. Factors which reduce muscle contractions, joint movements and lymph flow assist in localizing infection. With rigid immobilization the lymph flow almost ceases, joints above and below the inflamed tissues are immobilized. Without windows or dressing changes the infection will subside and inflammation will recede.

I have used Vitamin A injections for the relief of various and sundry plantar lesions. In many instances where the lesions sloughed, painful craters remained with replacement callus over the affected site. Conventional attempts at balancing or weight redistribution did not achieve the complete comfort our patients required to return to full duty. The application of a short leg walking cast for 3 weeks invariably led to complete comfort. With this phase of the treatment completed, we were able to arrive at successful conclusions in forefoot rehabilitation using traditional balanced modalities.

Physical Therapy

Regarding the use of physical therapy in the treatment of soft tissue injuries, it is not uncommon for individual podiatrists to treat such entities as bursitis, periostitis, arthritis, synovitis, etc., by strappings and periodic physical therapy consisting of heat and/or massage. All of these principles contribute to hyperemia. It is axiomatic that hyperemia causes decalcification of bone. and so while only the soft tissues are involved, adjacent bone close to the affected site comes within the hyperemic field and will show incidence of decalcification. This becomes a significant factor when treating chronic inflammation of the metatarsophalangeal joints. Consider traction and passive movements, commonly prescribed and often improperly understood and administered. These treatments essentially contribute to joint stiffening. It has been demonstrated that when adhesions about a joint are violently stretched, there is a reactionary exudation which will produce fresh adhesions. If this treatment is repeated, traumatic exudations reoccur, old adhesions are broken, but many new ones develop. Joints, especially metatarsophalangeal joints, stiff from trauma, should be stretched by the patient's own active participation. Adhe-

sions at the metatarsophalangeal joints are the result of repeated soakings with serofibrous exudates, arising from continuous trauma. With this in mind, how should we approach the traumatized joints that come to our offices, with toes hyper-extended and metatarsophalangeal joints swollen with fibrous exudate?

Treatment

It is reasonable to assume that for a period of 3 weeks the forefoot may be put to rest by plaster immobilization with the toes exposed and active exercise prescribed for them. It is important to prevent the toes from permanent immobility caused by repeated bathings in fibrinous serum. It is advantageous to mold the plaster into a high area under the central metatarsal heads. It is not appropriate to assign a definite period of time for soft tissue healing, but the patient's own comfort is the rule of thumb. When immobilization is discontinued for a new regime, it must be final. The patient is comfortable, active exercise and normal function are being carried on, reactionary edema has left the field, now rehabilitation involving balance, support, heat, massage, etc., may be employed.

Fractures

Now let us return to the treatment of simple uncomplicated fractures such as found in the tarsal and metatarsal bones. Twisting motions allowed by strappings permit tearing of granulation tissue and increase hyperemia to the injured area. Therefore, a crack or linear fracture may become a cavity or a gap. Our aim in the treatment of fractures is to reduce the hyperemia and decalcification. Regardless of age or apposition of parts, only inadequate immobilization interferes with healing.

After Care

The after care for the recently immobilized foot consists of two parts, the immediate care which facilitates the transition from rigid immobilization to complete return of normal function, and the restoration of adequate balancing and support to prevent further incidences. This point shall not be pursued here. To continue with the transitional phase, when the foot has been immobilized for several weeks, removal of the cast is followed by edema. This will increase during periods of activity and subside during evening rest. The circulation has become dependent on external support and reoccurring edema will continue until the musculature and circulation of the part are toned up by active exercise. The skin may show shiny and trophic changes around affected joints, frequent exercise is most important. Resist the temptation to stretch, massage and heat these edematous joints for the reasons described earlier. If you remember that massage disperses fluid temporarily and opens new channels from the capillary field, your patient may be protected from fresh joint adhesions. The use of an elastic support is essential to prevent continuous soakings of the tissues in fibroserum. The foot is positioned at a right angle to the leg when the strapping is applied. Adults require 5-6 weeks of elastic support, although months are not uncommon.

Summary

The repair of soft tissue injuries and fractures was discussed. It was pointed out that trauma is no more dependent upon absolute immobility for repair than any other therapeutic aid, for with all physiologic factors being equal the great majority of these injuries would heal without treatment. But, common sense reveals that those left to their own resources are attended by deformity, loss of function and chronic pain. Plaster serves our patients best by giving them immediate comfort. The injured part is put to rest while the patient may still pursue regular endeavors.

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Box 2552

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The Role of the Podiatrist in the Naval Service

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In this talk to you, I propose to discuss the role played by the Naval Podiatrist at Great Lakes, and via statistics and therapeutic comment show the value of having podiatry available in the medical service offered by the Medical Department at the Great Lakes Naval Training Center.

In order to better orient those of you who are not familiar with the Great Lakes Naval Training Center, I will describe very briefly what this complex comprises. There are about eight separate and distinct commands of varying personnel sizes plus a Naval Hospital of some 800 beds. Some Commands have a complement of as high as 22,000 men at a given time. Some Commands have very few military personnel, but there are about 30,000 military people on the station who are serviced medically, in one way or another, by the Medical Department. This is a Training Center, and the word training should be stressed emphatically with its close relationship to training, where a rather strict limitation of time is allowed for schooling and recruit training. This makes some forms of podiatric care, as will be discussed as a training procedure, as a weather eye must be kept on the calendar as well as on the patient's progress. Some of the patients will be in training for as short a span as 9 weeks, and others will be here for years (instructors and permanent personnel). All podiatry care is directed toward rapid therapeutics, efficiently carried out with a minimum loss of time in disposition of cases when applicable.

The Medical Department maintains approximately 300 active beds in our dispensaries, primarily for short term inpatient care, and some podiatry problems find themselves in bed for part of their therapy. No podiatry admissions are anticipated to be on the "Sick List" in bed for more than 3-5 days.

I established the Podiatry Clinic in the Recruit Training Command area of the Training Center upon my assignment to Great Lakes, as the podiatrist, in 1955. This location was selected because of the workload supplied by the Recruit Training Command. Recruits comprise approximately 65 per cent of the practice of podiatry, the remainder of 35 per cent from the 7 or 8 other Commands of the training center of which we service.

The Naval Hospital, which is a separate and distinct service hospital, services all military and dependent (wives and children) personnel in this area, and is in no way connected with the dispensary operation, except that we enjoy a rapport of free admission and consultation with the varied specialty services that are available at the hospital. The Medical Department is primarily a therapeutic operation, in deference to the hospital being both a diagnostic and long range therapeutic operation for those conditions which involve long procedure and follow-up. I personally have occasion to consult with the orthopedic, surgical, medical and dermatological services, and they are most cooperative in their disposition of diagnostic and therapeutic problems.

The physical location of the Podiatry Clinic is in the Recruit Training area, a dispensary of some 100 beds, a small, well-equipped, self-contained emergency room, an X-ray with lab, a hematology and urine laboratory, a physiotherapy room, administrative offices, two doctors offices, nursing station and a two room podiatry suite. Everything needed for diagnosis and therapy is readily available. The office hours are from 0800 to 1200 (usually a Diagnostic and Therapeutic Appointment Schedule is maintained) and from 1300 to 1600. These hours are for follow-up treatment and occasionally emergency foot care and reappointment availability is made for the P.M. hours. Patients are referred to the podiatrist, usually by the M.D.'s who are in all

other dispensaries, for their foot care and disposition.

In October of 1959, the Naval Field Medical Research Laboratory at Camp LeJeune requested information in regard to foot complaints seen at this Center. Since the Recruit Training regime presents extensive weightbearing periods of time and precludes sick call complaints in the foot, we submitted a study consisting of a statistical breakdown of specific diagnosis. I will present these to you with the hope of its showing some of the problems and the solutions to the problems in the practice of podiatry at Great Lakes Naval Training Center. I shall bring into the discussion a rather broad concept in therapeutics of the types of cases which will be discussed. The reporting period covers a 6 month period from 1 January 1959 to 31 June 1959, a representative 6 month period of time, although for the first half of any given year the total number of patients seen is smaller than the second half of the year, since recruitment usually is half again as high as it is the first half, but the statistical percentages usually are within a constant level.

Statistical Chart

	Average Recruit Pop.	Total No. Pts seen by Podiatrists	% Recruit Pop. with Foot Complaints
January 1959	6,746	290	4.3%
February 1959	8,890	320	3.6%
March 1959	10,180	420	4.1%
April 1959	8,417	400	4.8%
May 1959	6,517	575	8.8%
June 1959	8,505	782	9.2%
Total Average Population 6 Mos.			49,255
Total No. Patients in Podiatry Clinic			2,787
Mean Total % Recruit Pop. Seen in Podiatry Clinic			5.8%

The above chart indicates that 6 recruits out of any given 100 recruits had complaints referrable to the foot of such severity as to be sent for consultation and treatment at the Podiatry Clinic.

Note, there is an upward trend of patients seen in the summer months, but this a reflection of a higher recruiting policy which was explained above, coupled with the increased drilling activities which comes with the advent of more pleasant climatic conditions. The above figures indicate approximately 6 out of every 100 men who arrive in Recruit Training had foot complaints of such severity as to be referred to the podiatrist, during the 6 month period studied.

I mentioned a therapeutic discussion earlier in this paper, and I will go into that phase as I discuss the diagnostic breakdown. I would emphasize that these men are undergoing a rather rigid training program both physically and time-wise, so that all therapeutic measures are undertaken with an eye to the calendar to insure that the patients will not lose a great deal of time either from their training or job.

First on the agenda of diagnosis, and the most common cause for reporting to sick call for the podiatrist is what I call foot orthopedics. This accounts for about 30 per cent of all the sick call seen. This will include for simplicity sake the catch-all complaints of "weak foot, strain foot, flat foot, metatarsalgia, tenosynovitis and tendonitis, and a few congenital deformities and anomalies, although none of the above are considered to be a true diagnosis.

The first of the conditions to be discussed will be foot strain, this may be considered a traumatic condition, but in the sense of microtrauma, rather than violent trauma. (Violent traumatic injuries make up a group of complaints which of themselves comprise 20 per cent of all the complaints seen in the Podiatry Clinic.) The major complaints under the foot orthopedic heading are those syndromes of pain in both rear foot and forefoot, of any number of etiologies. Most of these conditions were existent prior to enlistment, but aggravated by their service occupation. Diagnosis of plantar myalgia (a phrase I like to use) is made after careful history and examination. History and examination are rather important, since some systemic diseases are manifested in similar complaints, i.e., rheumatic fever, rheuma-

toid arthritis, post-traumatic arthritis, allergic arthralgia and many other conditions. The area of Great Lakes includes a rheumatic fever center, and prophylactic penicillin is given all recruits who are not allergic to it to prevent the incidence of rheumatic fever, and this is a constant diagnostic problem since the disease stimulates the symptoms of foot strain or plantar myalgia. As we all know strep throats are precursors to rheumatic fever and as mentioned this area of the Naval Training Center is about the geographic center, with close living conditions, etc., of the beta hemolytic streptococcus.

Foot strain or plantar myalgia is treated once the diagnosis is established, via elastoplast strapping, physiotherapy and shoe padding where indicated. On occasions it is thought best to admit the patient to the dispensary for a few days of bed rest with physiotherapy, Q.I.D., and it is a great adjunct to those patients with severe weight-bearing difficulties, and makes them more receptive to any orthopedic correction, since the painful areas are much relieved by the bed rest. Admission depends primarily on the severity of pain and multiplicity of complaints. Muscular antispasmodics and relaxants have been used successfully with those cases of pain with accompanying muscle spasm. For the most part, these patients respond well to therapy, and do not lose any training time except on the rare admissions. One of the reasons for the good therapeutic result is the education of the patient to report promptly to sick call as soon as a complaint occurs and as a result the severity of the complaints does not get out of hand and they also respond to treatment more rapidly, since we don't have the problem of a neglected complaint to manage. This of course does not obviate any of the neglect which existed prior to enlistment. For severely symptomatic flat feet with pronation, forefoot abduction, etc., a regime of physical medicine, strapping and biplane appliances for plantar corrections is fitted to patients. A light duty period for a reasonable length of time is ordered and the results of this form of treatment are gratifying to both the doctor and the patient, since response to therapy is usually more than adequate. In some cases, because of a severe condition in a recruit which may be considered to be intractable due to service occupation, and is well documented to have existed prior to enlistment, patients with flat feet are separated from the service because of disqualifying nature of their complaints. The extreme loss of working time which would be required to make the individual's foot suitably asymptomatic and service eligible necessitates the discharge from active service of the patient. The decision is left up to the examiner and the patient is brought before a medical survey board and then discharged from the service for a pre-existing disqualifying defect. This procedure saves many tax dollars over the long course of time on treatment. However, on occasions the motivation toward remaining in the service is of such a caliber and though the patient has disqualifying flat feet which are symptomatic, a period of trial duty (full duty) with appropriate therapeutic measures being used, some rewarding results are gained, and a man is salvaged for active service. The utmost in discretion and selectivity is used in these cases, hence results are more gratifying under the above-mentioned therapy.

Tenosynovitis and tendonitis are complaints which are managed usually with tape immobilization in severe cases or elastic bandages wraps and physiotherapy with an attempt made to eliminate the causative factor. No further discussion is necessary in the therapy of these two disorders; albeit they are painful, the management is quite easy.

I should now like to discuss the dermatology phase of the practice of Navy Podiatry at Great Lakes, which makes for about 20% of the cases treated in the Podiatry Clinic.

Dermatophytosis pedis is the number one disease in prevalence, and because of the many manifestations of this entity the dermatologic axioms are rather closely adhered

to, i.e., if the skin is anhydrotic I moisten it, if it is hyperhydrotic I dry it, if its hyperkeratotic it is softened, etc. Once the acute and inflammatory symptoms have subsided fungicidal treatment is instigated. If bacterial infection develops and there is evidence of systemic spread through appearance of lymphadenitis and adenopathy, antibiotics are used systemically rather than topically, and occasionally bed rest and inpatient care is indicated.

The inpatient regime is proportional to the symptoms, and length of disability is proportional to the severity of the involvement. There are occasions where it does not appear that the skin will clear up in 4-5 days. The patients are admitted to the dermatology service at the Naval Hospital. Broad spectrum antibiotics, elevation of limbs and Burows or saline soaks prove most effective with secondarily infected dermatophytosis, and once all inflammatory symptoms have subsided fungicides are used for prophylaxis and follow-up management. The experiences with griseofulvin are limited, but is most effective when tinea cultures out strongly. The mycotic nail is the best indication for that preparation.

The next commonest skin disease is dermatitis venanata (contact dermatitis). The therapy is always directed to the elimination of the cause and the adage of treat what you see, i.e., therapy to alleviate symptoms. Patch tests are used rather frequently to find the causative irritant and after elimination of cause and symptomatic treatment the skin resolves itself. Conditions such as neurodermatitis, lichen planus, lichen simplex, ichthyosis, miliare, abscesses, furuncles, etc., are early managed and therapy is rather well defined once the diagnosis has been established.

Verrucae are the thorn in the side of most practitioners and there is no difference in the military with management and therapeutics than there is in civilian practice. These should really occupy a class unto themselves; however, since they are classed as skin conditions, they will be discussed in the dermatology phase. Any therapy of verrucae depends a great deal on size, location, appearance and the time the patient can afford. Electrical and chemical cautery are used as well as vitamin A injections and surgical excision. They are my choices of treatment and have been most gratifying. Occasionally after a series of treatments and recurrences they are referred to dermatology clinic for radiation therapy, but in my 8 years of practice I have seen radiation used only twice, and it is not as effective as one might think. Padding of shoes has also shown as adjunctive therapy while treatment of verruca is in progress. Results are gratifying if the criterion for therapy is judiciously adhered to and followed religiously, i.e., whether the verrucae are mosaic, if on a weight-bearing or irritated surface and size and number of the lesion. All of these factors go into the choice of treatment modality.

The next most prevalent condition seen in the Podiatry Clinic is the traumatic complaint. These complaints constitute 20 per cent of the sick call in the Podiatry Clinic, sprains being the most common, followed by myositis and fractures. Sprained ankles and ligamentous tears of the foot seem to have a higher incidence in the winter, perhaps as a result of the icy condition of streets, etc. Fractures of ankle and foot bones are common, usually as a result of direct trauma, and in the summer the incidence of stress or "march fractures" is most high.

Therapy of sprains is rather simple. X-rays are taken to rule out serious disturbances to ankle mortise and fractures of tibia, fibula and 5th metatarsal. Ice packs and strappings are applied if ankle is seen within 8 hours of trauma, and if the trauma and condition of ankle warrants it, a plaster walking cast is applied. If injury is of such severity as to warrant bed rest, patients are admitted to the dispensary where elevation, heat packs and whirlpool Q.I.D. are ordered until patient's condition warrants ambulatory treatment with either strapping or casting.

"March fractures" or stress fractures are

treated for the most part conservatively with elasto-plast strappings and weekly X-rays to follow the progress of healing. Bone callus forms rather rapidly with this fracture and once a solid mass of callus is visualized via X-rays, strapping is discontinued and physiotherapy is instigated. About 25-30 march fractures are treated annually in the Podiatry Clinic, and they present no real therapeutic problem. Inadvertently, these fractures usually occur in the 3rd and 5th week of training, and this is probably the most active phase of training and may be the cause of the high incidence of occurrence.

Another grouping of complaints, which makes up about 10 per cent of the sick call is corns and calluses. These are evaluated as to cause and treated with an eye to the elimination of the cause foremost. Excisions, tenotomy, padding shoe corrections, osteotomy, injections of steroids have all been used and results are most satisfactory. Emollient cream and keratolytic ointments are prescribed at times and results of all above therapeutics are most satisfactory.

Plantar callus, and deep plantar keratosis are evaluated via X-ray, palpation and history, to determine whether metatarsal length pattern defects are apparent or exostoses or hypertrophy may cause the complaint. Therapy, after either conservative or radical excision is always aimed at the cause, whether it be orthopedic or other (checking sock lining to see if plantar excrescence is not caused by a protruding lasting tack, or wrinkled sock lining).

The last problem to discuss in order of frequency is the nail problem. Ingrown toe nails make up about 10 percent of the complaints brought to the podiatrist, and therapy is almost exclusively surgical removal of the offending nail and/or matrix by resection. This procedure as done in my office is relatively atraumatic and presents no great time loss from duty. Infection is always "cooled off" before surgical intervention, and follow-up has shown a very low recurrence rate. The lack of recurrence has proven the feasibility of the technique on an outpatient basis. Postoperative care is soaks with Burows solution and light duty status and extremely careful follow-up. The grooves are packed postoperatively with Gelfoam®[1] and this obviates the need to remove postoperative packing.

Paronychia and onychia occur, but present no serious therapeutic problems.

Onychauxis and subungual hematoma secondary to trauma are easily managed in the simplest means, and subungual exostosis are excised surgically when convenient to the patient, since this involves a loss of training time. The above complaints as stated present no serious problem and are readily managed with little or no lost time.

Summary

Foot problems are divided as follows: Foot Orthopedics 30 percent, Dermatology 20 percent, Violent Trauma 20 percent, Onychopathy 20 percent, Corns and Calluses 10 percent.

The role played by the podiatrist in the Naval Service is rewarding both to the practitioner and the patient. It also serves to free the Navy Medical Officer for work for which he is better trained and takes the pesty foot problems out of his office into that of the trained specialist where they belong. This again shows the value of competent specialty care in a large organization of military such as the Great Lakes Naval Training Center, and raises the level of professional care given the patient by a specialist trained in the art of healing a sick foot.

Note: The opinions expressed in the above paper in no way reflect the opinions of the Naval Service, and are of the author entirely. The treatments are acceptable to the Naval Service and meet with the approval of the Director, Medical Department, Great Lakes, Illinois.

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Naval Training Center

[1] Upjohn Co., Kalamazoo, Mich.

Report on Department of Defense Research Project Relative to Combat Boots Made Over a New Type of Last

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In 1943 the Surgeon General of the Army reported that 13,050 cases of traumatic foot injuries were incurred in the United States, 7,375 caused by ill-fitting shoes and 3,045 caused by drilling and marching. The cause of the remainder was not stated. Conceivably, ill-fitting shoes may have contributed to some of the injuries caused by "drilling and marching. As a result of this report from the Surgeon General regarding foot injuries, anthropometric studies of the feet were conducted at Fort Knox, and it was determined that shoes and boots built over the Munson last are not satisfactory footwear for the American soldier. The main defects of the Munson last are: a. It is an inflare last, b. The heel to ball dimension is too long, c. A large tariff of sizes must be stocked.

Recommendations were made that new military footwear be designed over lasts which conformed to the mean foot dimensions obtained by the anthropometric studies. In 1949 an attempt was made to modify the Munson last to conform to the measurements and as a result the Fort Knox IV Last was devised, and it is over this last that most of the Army low quarters in use today are built. Further testing resulted in the decision that this last, the Fort Knox IV Last, was not satisfactory for use in manufacturing the Army combat boot. Another last, the Fort Knox V Last, was designed from the start to conform to the mean anthropometric dimensions of the American male foot and was declared superior to either the Munson or the Fort Knox IV last in manufacturing the Army combat boot.

Meanwhile, advocates of the built-in arch support or "antipronation device" appeared on the scene and were successful in having the Fort Knox V Last modified to incorporate this device. The Functional Fort Knox V Last (with the antipronation device) and the Conventional Fort Knox V Last (without the antipronation device) were tested over a period of time at Fort Devens and Fort Benning. The tests were conducted in respect to fit, comfort and clinical effects during an extended testing period jointly by the Quartermaster Corps and the Army Medical Service. The results of these tests at both test sites were similar and no visible defects or abnormalities were caused by wear of either type of boot. Approximately 50 percent of all the test subjects stated a preference for the functional boot which contained the antipronation device. On the other hand, nearly 30 percent of the test subjects were unable to wear the functional boot due to the discomfort of the built-in arch support. As a result of these tests, the Fort Knox V Conventional Last was recommended for Adoption for Army footwear. This recommendation was concurred in by the Surgeon General of the Army in March of 1959.

As noted previously, one of the main defects of the Munson Last was the fact that a large tariff of sizes and widths must be stocked. The Quartermaster Corps expressed an interest in this testing because if the new last was adopted then a reduction in the tariff of sizes and widths from the present 60 to 32 or possibly 28 could be realized. In addition, it is desired that this new last, if adopted, should be uniform for all four services—Army, Navy, Marines and Air Force. Thus, one can readily see what a large savings could be realized over a very short period of time if one boot, made over one last, were adopted for use by all the services. In addition to the savings in dollars and cents, the problems created by storage, inventory and transportation would be greatly reduced.

The primary interest of the Army Medical Service is to decrease the number of foot injuries each year at Army Medical

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Treatment Facilities all over the world which in the past have been attributed to misfitted footgear. All of the tests conducted over the past 15 years point to the fact that the misfitting of footgear is in a great part due to the design of the last over which the Army shoe and boot are constructed.

For the information of those of you who may not be fully acquainted with the Munson Last, a quick review may be in order. Back in the days prior to World War I, Major Munson, MC, an Orthopedic Surgeon of the Army Medical Service, showed a continued concern over the fit and shape of the shoes and boots our soldiers were wearing in those days. His research on this matter went back prior to 1912 and about the time of World War I he devised what was to become known as the Munson Last. Major Munson's studies of the foot ills of the American soldier and his footgear was the first attempt that was made to devise a last which would be practical for military purposes. The last that he devised, although it has been modified many times since its inception in 1918, has been in continual use since that time up to the present day. Although the original last left a great deal to be desired as we view it today, it was a great improvement over what had been in use up to that time. Statistics are not available, but I would judge that the incidence of foot ailments showed a decided decrease after his innovation was adopted. The American soldier certainly owes a debt of gratitude to this renowned orthopedist who brought him comfort for the first time.

Through the years many modifications to the original Munson Last have been made. Despite the numerous changes, the surveys conducted back in the early 1940's disclosed that an entirely new concept in our lasts must be developed. Thus, the Fort Knox V Last was devised and at the present time is in its final testing phase.

The Fort Knox V Last is so designed that it achieves a greater conformity with foot characteristics than does the Modified Munson Last. Namely, the analysis of the data accumulated showed that the great majority of the feet of our soldiers were characterized by some degree of "outflare." The Munson Last was an "inflare" type of last. Although the selection of one average shape for the revision of the present last is not completely ideal, it will, nevertheless, constitute a decided improvement. In addition, the uppers of the Combat Boots made over the Fort Knox V Last will conform to the general contour of the foot much better than those made over the Munson Last. The present new Fort Knox V Last is so designed that it will increase proportionately in all dimensions by approximately 6 percent as the size increases. This should afford a great deal of improvement in the fit around the ankle, over the vamp, through the toe box, and around the heels. The anthropometric studies conducted at Fort Knox back in 1943 showed that the Munson Last left a lot to be desired for fit of the combat boot to the foot in these areas. In other words, the Fort Knox V Last is made on a geometric principle. It is hoped that if this principle is finally adopted it will be possible to fit nearly every American soldier with a combat boot without resorting to half sizes. Tests conducted a few years ago showed that soldiers could be fitted in combat boots made over the Fort Knox V Last utilizing the full sizes only without developing any noticeable defects or lesions to the feet. In addition, a large majority of the test subjects reported that the new last was more comfortable than the one they had been wearing.

Based on the results of extensive user testing, the Commanding General, U. S. Continental Army Command, recommended that the Fort Knox V Last be adopted for Army use. Concurrent with the Army user testing, the U. S. Marine Corps was furnished a test sample of combat boots made over the Fort Knox V Last for field testing by Marine Corps troops. Based on the results of the Marine Corps test, the combat boot made over the Fort Knox V Last was not recommended. These tests were made in order to get concurrence of the Marine Corps in the adoption of universal footwear

for the military services. The incidences of blisters and other foot disorders in those Marines who wore the boot were reported as twice as high as it was in those who wore the standard Marine Corps boots. These results were completely inconsistent with those of the Army test in which there was no such difficulty encountered. As a result the entire project was brought to an abrupt halt and a critical re-evaluation of the whole boot situation was undertaken.

As a result of this re-evaluation of the whole boot situation, it was decided in September 1959, at a meeting of various Deportment of Defense agencies, that further tests of the new boots were indicated. It was further decided that the tests would be supervised by a joint test team and would be conducted under as nearly uniform and comparable conditions as possible. These tests would be conducted by the Marines at an East coast training center and by the Army at my present station, Fort Bragg. Test subjects would be applied from units training at both sites. It was further decided that boots to be tested would be: 1. Modified Munson Last, 2. Fort Knox V Conventional Last, 3. Marine Corps boots built over its standard commercial last, 4. Marine Corps boots built over Fort Knox V Conventional Last.

Fitting of all test boots at both sites would be carefully done by enlisted personnel trained at the Quartermaster Corps laboratories.

It was further directed that the Army Medical Service would participate in the test by evaluating any complaints of discomfort or foot disorders that may develop in test subjects. This aspect of the program was assigned to the U. S. Army Medical Research and Development Command of the Office of the Surgeon General. As a result, the Surgeon General saw fit to direct that the foot examinations and evaluation of the medical aspects of this test be conducted by a commissioned podiatrist. The Marine aspects of the test would be evaluated by an orthopedic surgeon of the Navy attached to the Navy Hospital at the Marine East Coast Training Center. In early 1960 I received orders from the Office of the Surgeon General directing that I report to Fort Bragg, N. C., to act as "Professional consultant for the boot evaluation team tests in cooperation with the Navy and Marine Corps." I arrived at Fort Bragg in April 1960 and immediately proceeded with carrying out my assigned mission.

The first consideration in the evaluation of this test was to conduct an initial examination of the feet of all test subjects. This served two purposes. First, it gave us a control to determine the appearance of the foot and to note any deformities prior to wearing the test boots. In conjunction with this, the appearance of the foot and the noted deformities at the time of the final examination will be compared with the findings prior to wearing the test boots. Secondly, those individuals that were found to present feet with severe abnormal appearances and deformities were deemed poor test subjects and not carried any further in the test.

The first part of the Initial Examination Record contained basic data: name, rank, unit, age, years of service, height, weight, regular shoe size, and a history of past foot diseases or severe injuries. In the second part, the appearance of the foot, we noted the relative height of the arch (longitudinal), whether the feet were pronated or supinated, any heel prominences, and abnormalities of the toes, namely whether they were contracted, excessively long or were overlapping. The third part consisted of a notation of deformities such as a hallux valgus, prominent tarsal navicular, ganglia and so forth.

Following the initial examination a Clinical Record was made out on each test subject. In this it was noted whether there was any evidence of callus, blisters, vesicles, abrasions or erythema. If there was no evidence of a particular lesion, an "0" was placed in the criterion column. If a lesion or condition was present, then the numerical designation of 1 through 4 was placed in the criterion column to designate its

degree of severity, slight, mild, moderate or severe. In addition, the observed condition was noted on a chart containing an outline drawing of the feet and located by a lettered designation. Following the foot examination the test subject went to the next building where he was fitted in one of the test boots.

The feet of 600 test subjects were examined and all were fitted in test boots. The size designation in all boots was obliterated and the type of boot was coded as either A, B, C, or D. 150 test subjects were fitted in each of the four different types of test boots. For example, 150 were type A the first wear period, 150 type B, etc. Each test subject wore the boot for a 4-week wear period. At the end of that wear period he returned and his feet were re-examined to note the presence or absence of any conditions or lesions and whether or not any new ones developed or previously noted ones increased or decreased in severity. These observations were noted in the next column of the Clinical Record which was originated at the time of the initial examination of each test subject. Following the foot examination the test subject turned in his test boots and received his original issue boot in return. This he wore for 1 week and at the end of that time he returned for his foot examination for the beginning of wear period II. The purpose of this 1-week recovery period was to allow the test subject to recover from any conditions that may have occurred while wearing the test boot during the previous wear period before being issued another pair of test boots.

If a test subject wore type A boot during the first wear period, he was issued type B for wear during wear period II. If he wore type D, he was issued type A for wear period II. Thus, during the 4-week wear periods each test subject will have worn each of the test boots for 4 weeks.

It should be noted that at the completion of each wear period each test subject is interviewed by trained personnel of the Quartermaster where information is obtained regarding the test subject's feelings on the fit, comfort, likes, dislikes and other remarks which may be forthcoming.

At the completion of the first phase of the test, all the medical information, as well as all the information obtained from the interview forms, will be compiled and evaluated. The same is true of the information which is being compiled by the Marine aspect of the test which is running concurrently with the Army test. When all the information from Phase I has been analyzed, a decision will be rendered as to what two boots are considered the best of the four tested. When this decision is made, Phase II will get under way utilizing soldiers and marines who were not involved in Phase I. At the completion of Phase II it is expected that one boot will be chosen as the best and it will be recommended to the Department of Defense that this selected combat boot be designated as the uniform boot of all the services.

As podiatrists we appreciate having the Surgeon General utilize one of us in a position for which we are particularly educated and trained and which is a field in which we are well qualified to render a complete and scientific opinion. The fact that our specialty has been asked to render an expert opinion on the evaluation of this newly devised last is not the first time in the history of the Army Medical Service that the podiatrist has been called upon for his assistance in this test. In going through the background material available which preceded the actual development of the Fort Knox V Last, I noted that "chiropodist" is mentioned several times in the report on the "Design and Fit of Army Shoes" as submitted to the Office of the Surgeon General in 1945. In addition, the bibliography of this report credits Dr. Frank Carleton's book, "Shoes and Feet," and also refers to an article written by Drs. Schwartz, Heath, and Misiek titled "The Influence of the Shoe on Gait" which appeared in the April 1936 issue of the *Journal of the National Association of Chiropodists*. It was also noted that while reviewing the information regarding the

anthropometric studies which were done in 1946 that the words "chiropody" and "chiropodist" appeared several times. I suspect that there was a chiropodist involved in all these tests although the reports fail to mention this fact. As you can well see, podiatrists in the past as well as the present time have and are being called upon by the Army Medical Service to act as professional consultants on matters which pertain to our specialized field. I, for one, can assure you that the Army Medical Service appreciates the services we render and that our ability is well recognized and utilized at the Army installations where podiatrists are assigned.

Womack Army Hospital

New Stretch Nylon Shoe Lace as a Therapeutic Aid

Rob Roy McGregor, D.S.C.*
Concord, Mass.

PRELIMINARY trials on office patients of a new shoe lace made entirely of stretch nylon yarns (A-Live®) gave surprisingly consistent reports of greater shoe comfort. Supporting these reports, several instances were noted of reduction of inflammation on the dorsum of the foot which had been due apparently to excessive pressure from the lacing of the shoe. A larger and better controlled test which would include various conditions characterized by shoe-foot incompatibilities, seemed indicated.

The second test was made on 130 office patients and residents and employees of health institutions. Of these, 105 were patients under active treatment for foot complaints as classified below and 25 were people who had no foot complaints but did have problems with shoe lace durability or knot holding. Each case was followed over a 6-month period.

Classification of Test Cases

In order to qualify for the test, a patient had to present bilaterally one or a combination of the following circumstances:

1. Dorsal hypertrophy of 1st metatarso-cuneiform joint was present, with or without heloma miliare, but with inflammation.

2. Shoe-foot incompatibility was present, even though the shoe was the best available, but the foot either (a) was splayed and forward riding or, (b) had a high instep or was thick waisted.

3. There was need for closer fit of foot to appliance or paddings.

Test Procedure

Every effort was made to narrow the observations to the effects of the test lace alone and to introduce the lace to all subjects in a standardized and unbiased manner. In all hypertrophied conditions, no shoe eyelets were removed or other changes made that might affect the results. Simple lacing and regular bow knots were used, without reversal of lacing through the top eyelets or double knotting, frequently used on regular laces.

In all cases, the test lace was substituted initially in only one shoe to obtain a comparison with the regular lace in the other shoe. Each patient was given the old lace that had been removed and a second test lace, but with instructions not to change laces for at least a week and then not without reporting first by telephone. Each patient was told that this was a test of a new lace to see if it had any advantages for him.

Results

1. Hypertrophied metatarso-cuneiform joint with inflammation.

® Pepperell Braiding Co., Inc., E. Pepperell, Mass., who supplied the laces used in this study.

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In all 16 cases, resolution of inflammation was complete. The hypertrophy, naturally, was not reduced. Initially in each case there was present not only rubor, but also swelling, which exaggerated the hypertrophy. It is this which gives the patient the problem and which was resolved by the use of A-Live lace. "Seed" corns did not return after initial reduction.

Three cases had ineffective aperture tongue pads when first examined. These "doughnut" pads were left in place until the swelling was reduced and then discarded.

Everyone in this group was afforded a specific aid by the use of the new lace. However, it must be understood that at no time can the lace supplant the need for a proper shoe fit or overcome the adverse effect of a wrong fit.

Our Case No. 2 is a good example of patients in this category. R. W., a pharmacist with hypertrophied 1st metatarsocuneiform joint dorsally, bilaterally. These joints were a chronic problem, quite enlarged and inflamed. The patient had sought professional attention but was dissatisfied. Immediately after placing the test lace on the shoe which had the larger foot, he was called out of the office. Returning 5 minutes later he said, "My shoe feels more comfortable." Redness was gone in 2 weeks, swelling in 2 months and patient reports consistent shoe comfort greater than ever before attained.

2-a. Shoe-foot incompatibility, splay foot and forward riding.

In this instance, "splay foot" refers to that foot characterized by excessively elastic ligamentous tissue which allows the foot, on weightbearing, to elongate to a marked degree and the forefoot to spread laterally. This automatically creates a foot with a wider ball and narrower heel. Hallux valgus of varying degrees may be present.

Thirty-nine cases were included. Twenty-six, or two-thirds, reported marked improvement in comfort and support from the shoe with the new lace; one-third reported moderate improvement. In all cases it was evident that better control of the foot and shoe was obtained with the new lace.

Case No. 17 is typical. Mrs. O. S. had an early hallux valgus with hallucial nails beginning to involute due to the crowding tendency of the hallux in its valgus position and the forward thrust of the toe. Shoes were fitted and padded to help control the problem. When the shoe was tied tightly with the conventional lace to hold the foot back, the pressure on the dorsum was painful. Immediate comfort was noted when the test lace was used. The foot was now held back and the forward riding less marked.

It should be noted that the stretch nylon lace has an available stretch of considerable magnitude that pulls out at a very low tension. All use of the lace is at a higher tension, where the remaining stretch or "give" is of a low magnitude, but greater than ordinary laces, and without the retraction power of rubber elastic laces. This unique extra "give" contributes to comfort at moments of abnormal stress, but recovers slowly and does not result in loosening of the lace.

2-b. Shoe-foot incompatibility, foot has high instep or is thick waisted.

Twenty patients were tested of whom 16 had very marked success, 4 moderate. Individuals with a high instep or thick waisted feet, usually object to wearing oxfords, saying, "I never could wear an oxford because . . . ". Sometimes they may allow themselves to be fitted to a shoe that would accommodate this problem, but more often they are adamant. It is difficult to evaluate how much of this resistance is imaginary and how much real. However, we do know the problem is not insurmountable, as proper shoes are readily available. One of the dramatic effects noted in the use of the A-Live lace was its result in this circumstance.

Case No. 3 is an illustration of particular interest because treatment had been considered concluded before the new lace became available. Mrs. V. McG., whose Morton's neuralgia was controlled by office

treatments, balked at being fitted to low heel oxfords, "just look at that high instep." Under duress, she was fitted and pads were placed in her shoes. The neuralgia was controlled and apparently successfully maintained. Two months later, by chance, the author met the patient who was not wearing her "proper shoes." Upon questioning, the patient said her feet were as bad as ever because, "I told you I couldn't wear those shoes." The patient was asked to try the new lace. She acceded and in 3 days called to ask permission to insert the new lace in the other shoe. A 6-month check found her happy and pain-free in the "proper shoes."

3. Closer fit needed.

This category encompasses 66 patients including some in the above, more specific categories. A 2-1 ratio of marked to moderate success was noted, with the exception of one elderly lady who stated that nothing helped and the new lace made no difference.

Typical was Case No. 49, Mrs. R. K., a severe arthritic with a prominent hypertrophied and fixed medial sesamoid under a hallux valgus presented herself with a moderate ulcer of this area. Careful padding and weight bearing control resolved the problem. Balanced latex inlays were fitted to the feet and then new shoes were fitted. Patient seemed to be in good control until 3 months after last visit, when she was back with the beginnings of the same problem. It seemed that her feet had a tendency to swell and, though the inlay was well fitted, by mid-afternoon there was so much swelling that the inlay, and finally the shoe, had to be removed with loss of weight distribution control. After clearing up the ulcer again, the A-Live lace was used and the patient was gratified to find that the laces yielded with the swelling and she could keep her inlays and shoes on all the time. Six months later the patient was ulcerless and comfortable and the excessive swelling was less, due to adequate weight distribution control.

The problem of shoe laces coming untied or loosening is particularly common in children and the aged. This is especially troublesome in treating children with shoe pads or appliances where it is so essential to maintain a tight-laced shoe. The children used in this test, and their parents or guardians, were all previously acquainted with proper lacing and tying procedure so that their report of lace performance would be as valid as possible.

Improvement in knot-holding ability was reported generally throughout this test and in all cases of the 25 especially treated. Of this latter group, 16 were markedly improved, 9 moderately. In all cases, durability was far superior to the conventional lace.

The question of greater comfort is the common denominator for all of our patients as well as for the many people who never visit a podiatrist. It is generally the least tangible complaint and in this test is, of course, the most subjective observation. The degree of success reported here as "marked" or "moderate," reflects the effusion of the patient's expression and is often dependent on the amount of discomfort the patient had been experiencing previously.

One other area where the A-Live shoe lace merits consideration is in recreation-athletic pursuits. The author has difficulty achieving the proper tension with his carefully fitted ski boots and ice skates and has suffered frostbite. In the past it was frequently necessary to re-tie the boots or skates to maintain the proper degree of tension and still not make the boots or skates too tight, especially in sub-zero weather. At best this was a nuisance. Tests made with the A-Live ski lace this past winter were eminently successful. Retying was seldom necessary and frostbite was never a problem. The demands for proper tension and holding of a lace in tennis sneakers, likewise, are successfully met with this lace.

The author believes that the role of the lacing and the possibilities of improving on it have not been fully appreciated in the past as an integral part of podiatry treat-

ment. This new stretch nylon lace is a simple device to improve the functioning of shoes, appliances and pads, while increasing patient comfort and tolerance for his treatment.

Summary

A new shoe lace made from stretch nylon was tested on 105 patients having congenital and acquired conditions which fall into the broad category of shoe-foot incompatibility plus a separate group of 25 who had shoe lace problems but no foot complaint.

Specific relief of pressure on bony hypertrophies on the dorsum of the foot was observed in all cases. Resolution of the inflammation was complete, with all reporting greater foot comfort.

Closer fitting of shoes, appliances and pads was possible with the new lace, with increased comfort. Such tightness was better maintained and greater freedom from loosening and untying found.

Of the entire group tested, all reported greater foot comfort but one. A majority found the improvement very apparent.

Further application of this lace in recreation-athletic pursuits deserves consideration.

In the author's opinion, A-Live lace offers a new and valuable tool to the profession and more attention should be given the lacing in pertinent podiatry cases.

Concord Medical Center

An Effective Topical Anesthetic for Podiatry

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Paris, Ill.

One may define anesthesia as the loss of feeling or sensation, especially the loss of tactile sensibility.[1] A local anesthesia produces its effect by blocking nerve conduction when applied at or near nerve tissue in effective concentrations. This effect can be obtained by topical application or by injection.

The purpose of this paper is to discuss a spray topical anesthetic, Cetacaine,®[1] its indications and applicability in podiatric practice. I have used Cetacaine in my practice for over 8 months. There has been a marked removal of apprehension and fear on the part of the patient. I have had better results in the treatment of children, since the use of Cetacaine, than at any previous time in my 25 years of practice.

An ideal topical anesthetic should be nontoxic and nonirritating to the skin. It should not damage nerve tissue, yet should bring on its effect rapidly, with ease of application. Duration should be adequate to carry out the surgical procedure. The agent should be stable and have adequate shelf life. Careful observation of hundreds of patients showed no toxic or side effects when Cetacaine was used. Maximum anesthesia was obtained in about 45 seconds, with an operative duration of approximation 30 minutes. Cetacaine is aerosol packaged for simple spray application and may be reapplied, if required, under normal operative conditions. The ease of application and speed of onset are of much importance to the busy podiatrist.

My first applications of Cetacaine were for inflamed or infected ingrown toenails and very sensitive helomata. The results were so good that I have adopted its use prior to any procedure where pain might be anticipated in the treatment. Cetacaine is not indicated for use on normal skin, but will be found effective where skin is inflamed and open or where skin has been broken, so that the anesthetic may come in contact with underlying tissue. It is also

®[1] Cetylite Corp.

effective on skin where softening agents have been applied prior to the removal of callus tissue.

The following is a list of conditions where Cetacaine has been used and found to be most effective: 1. Before the removal of excrescences, (a) Heloma Dura, (b) Heloma Molle, (c) Tyloma, (d) Papilloma; 2. Treatment of ingrown toenails, (a) Inflamed, (b) Swollen, (c) Infected, (d) Thickened, (e) Exuberant tissue (proud flesh); 3. Before injection, (a) Minor surgery, (b) Lancing; 4. Treatment of verrucae, (a) Debridement, (b) Chemical cautery, (c) Electric cautery; 5. Removal of foreign bodies, (a) Splinters, (b) Hair, (c) Glass; 6. Treatment of wounds, (a) Wound drainage, (b) Curettage, (c) Accidental hemorrhage, (d) Eliminating sting of styptic solution.

Cetacaine has been widely used by the dental profession for a number of years. In recent years this products has been adopted for use by the Eye, Ear, Nose and Throat practitioners. It has, in a published report, fulfilled requirements for an ideal topical anesthetic.[2]

Since Cetacaine is a topical anesthetic, there is no stimulation or depression of the central nervous system. Age is not a factor in the selection of cases and in my practice, the drug has been applied to children and adults with equally excellent results.

There are many methods of producing anesthesia from the surface, such as cold, pressure to the nerve trunk and chemicals applied to the skin. Most of these methods have too many objectionable features for practical application by the podiatrist. The pressure method is not practical because it requires too long a time to maintain. Chemical irritants such as phenol can injure and destroy nerve endings.[3] My experience with ethyl chloride has been immediate patient complaint of coldness and then of after pain. I have never been successful in obtaining complete anesthesia with ethyl chloride.

One of the basic active anesthetic drugs formulated into Cetacaine is tetracaine 2% (pontocaine), which is a fast-acting anesthetic, but having only short duration of anesthesia. Tetracaine has long been recognized as an all-purpose anesthetic. Adequate anesthesia for the mucous membrane of the oral cavity, nose and throat, can be obtained with a 2% solution.[4] Also incorporated are ethyl aminobenzoate and butyl aminobenzoate, slow-acting anesthetics, but having longer duration and becoming effective prior to loss of effectiveness of the fast-acting tetracaine. This compounding makes for continuous acting anesthesia for the full 30-minute period. For antibacterial control, a combination of benzalkonium chloride and cetyl dimethyl ethyl ammonium bromide has been formulated into Cetacaine, resulting in salts of high antibacterial activity.[5]

Cetacaine spray topical anesthetic is packaged with a tubular type metal tip, which responds easily to finger-tip control. A 1-second spray releases approximately 1/10 cc. of the formula.[6] This is adequate to anesthetize an area of ½ to 1 centimeter in diameter and will produce maximum anesthesia in about 45 seconds.

Results and Conclusions

Cetacaine is an effective topical anesthetic for podiatric practice. It is safe, nontoxic, giving adequate length and depth of anesthesia and having antibacterial properties. Because of its high anesthetic properties, it eliminates patients' anxieties and fear of podiatric treatment. East of handling and rapid onset and long duration of anesthesia, result in the saving of time and tension for the busy clinician.

115 E. Washington St.

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Foreign Body Removal with the Aid Of a Metal Locator

S. David Geller, Pod.D., F.A.C.F.O.
Lawrence, N. Y.

As recently as January 1961, Kozie[1] stated, "There have been attempts at surgical removal of an embedded needle which have extended up to 7 hours with nothing more accomplished than mutilation of tissue, and, in some cases, X-ray burn." Kahn,[2] in discussing removal of a foreign body, describes " . . . two semi-elliptical incisions *** extending from the 3rd metatarsal head obliquely, posteriorly toward the midshaft of the 2nd metatarsal. Overlying skin excised, incision deepened . . .". Descriptions of foreign body removals are by no means limited to podiatry publications. Wolfe and Lozman[3] describe the Location of a Metallic Foreign Body in the Abdominal Cavity and Malone[4] writes of his Experiences in Handling of Intraorbital Foreign Bodies.

In the main, podiatric surgeons probe and search for foreign bodies without the aid of a metallic locator. I have no actual data but logic leads me to surmise that podiatrists see a major share of needles in the foot. We should, therefore, become acquainted with an electromagnetic device called the Berman Metal Locator.

The metal locator was first used extensively at Pearl Harbor, following the Japanese attack. A New York surgeon was in Hawaii delivering a series of lectures on the use of the instrument when the opportunity for its first major test under fire was presented. The successful results obtained at Tripler General Hopital following the attack proved the "locator" to be a real contribution to the field of foreign body surgery.

The use of the locator transforms certain foreign body removals from a more or less uncertain procedure to one of high precision.

The locator operates by electromagnetic induction, employing a thin, pointed probe for detection of the foreign body. Localization is determined by indications on a meter and a small loudspeaker operating simultaneously. Both of these are on the panel of the electronic amplifier to which the probe is connected. When the instrument is set for operation, it is adjusted to give a sound of uniform pitch which remains unchanged until the probe approaches the metallic foreign body. Then the meter reading and tone pitch both rise sharply. As the probe passes beyond the site of the foreign body the meter reading and tone pitch both drop. The point on the surface where the peak indication occurs, marks the closest approach to the foreign body. Intervening tissue does not interfere in localization.

When used within the incision, the probe is covered with a jacket of thin surgical rubber which can be autoclaved.

The following case is a report on the use of this instrument.

A healthy 15-year-old female stepped on a needle in the forenoon. That afternoon she limped into the office in considerable pain. X-rays revealed a foreign body 1.5 cm. in length, less than 1 mm. in width (obviously the needle) plantar to the head of the 3rd metatarsal at about 45° angle to the plantar surface and 30° from the long axis.

The patient was hospitalized. C.B.C. and urinalysis were ordered. Patient was given .5 cc. tetanus toxoid, 400,000 u. penicillin and 800 mg. Miltown®[1]. That evening the patient was scrubbed and anesthetized with 4 cc. Xylocaine®[2] 2% with 1:100,000 epinephrine at posterior tibial and 4 cc.

proximal to intended incision. A Berman Metal Locator was obtained which located the needle slightly posterior to the X-ray position.

A ½" incision was made following the skin lines. An ophthalmic magnet was tried unsuccessfully. The edges of the incision were retracted and the needle sought with the deep probe. It was necessary to lengthen slightly the original incision. The metal locator directed us to the nearer end of the needle. The force required to withdraw the needle indicated that the point had become lodged in bone. The wound was flushed with sterile saline and closed with 3 interrupted silk sutures. A pressure bandage was applied.

Darvon®[3] Compound 2 Stat. and 1 q.i.d., and penicillin 400,000 u. b.i.d. were ordered. Patient was ambulatory in 12 hours. The incision was redressed on the 4th day, sutures removed on the 10th day and patient discharged 1 week later.

The ease with which the needle was found and retracted, the minimal trauma involved and the speed of recovery, suggest that any other method of metallic foreign body removal is archaic, potentially dangerous and unnecessarily brutal.

The cost of a metal locator and infrequency of use preclude purchase by individual practitioners. However, many good hospitals have the apparatus. When confronted with such a case, an effort should be made to obtain the use of the locator. Usually an ophthalmologist will know where one is obtainable.

®[1] Wallace Laboratories
®[2] Astra Pharmaceutical Products, Inc.
®[3] Eli Lilly & Co.

Summary

A method of metallic foreign body removal is described a and case reported. It is hoped that this report will help introduce this instrument to podiatrists.

285 Central Ave.

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Errata

Two errors appeared in the Book Review on "Modern Drug Encyclopedia and Therapeutic Index," page 427, June 1961 Journal.

The left column, 2nd paragraph, 5th line should read: "Food and Drug Administration."

Right column, 3rd paragraph, item 1, should read: "1. Product brochures which present new . . . . "

Dr. Carpenter's article on "Results of a Four-Year Study of Injection Therapy in the Treatment of Plantar Warts" was submitted to the 1960 William J. Stickel Awards for Research in Podiatry-Chiropody, not the 1961 awards.

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

President's Page

49th Annual Meeting—Communications

COMMUNICATIONS is the theme of the American Podiatry Association's Annual Meeting for 1961, to be held next month, August 26th-29th, at the beautiful AMERICANA HOTEL, Bal Harbour, Miami Beach, Florida.

The Annual Scientific Meeting of the A.P.A. is THE SHOWCASE of our wonderful profession. This is the one major time each year that we gather together all of the membership of the profession to discuss, to observe, to listen, and to learn for the advancement of podiatry-chiropody and for the public interests.

This Meeting becomes the major source of valuable information to be communicated into many phases, namely:

Public Education and Information; Public Relations; Inter- and Intra-Professional Relations; Industrial and Labor Relations; Insurance Relations; Governmental Relations; and Community Relations, to mention but a few.

As a result of my experience this past year, I can confidently say that we have great need in our profession for the development of proper communications and protocol within the profession, as well as proper communications with all allied health agencies and other external agencies. We cannot afford unilateral action on the part of any group or individuals within the profession.

This has been the source of some setbacks and a certain amount of embarrassment, which must not be repeated.

Because this year the theme is COMMUNICATIONS, it behooves all who possibly can to participate in this wonderful display of our profession in Florida. Let this be a wonderful outing for your family and give yourself the opportunity to assist in properly communicating your profession, PODIATRY-CHIROPODY, to the public at large.

See you in Miami Beach!

MARVIN D. MARR, D.S.C.

49th Annual Meeting Preliminary Program

The COMMUNICATIONS theme of the 1961 Annual Meeting is interwoven in the Breakfast Sessions, one General Session and in some of the Group presentations. Communications is an integral part of professional practice and therefore should never be divorced from scientific ability and knowledge. The more effective are the communications practices between the podiatrist-chiropodist and those with whom he contacts, the greater will be the contributions of podiatry-chiropody in the public welfare. Communications patterns are assuming more and greater importance within all health fields and the APA-NAC Annual Meeting of 1961 will highlight some of these fields.

A typical day will start with the Breakfast Sessions from 7:30 to 9:00 a.m. (with the exception of Sunday), continue with Group Sessions from 9 a.m. to 11:00 a.m., and conclude with the General Sessions from 11:30 a.m. to 1:00 p.m.

Again this year, portions of each Scientific Session have been approved by the Armed Services for retirement point credit for those reserve officers in attendance.

SCIENTIFIC SESSIONS

GENERAL SESSIONS

Four outstanding general sessions have been planned for the Annual Meeting this year. General Sessions will be held from 11:30 a.m. to 1.00 p.m. on Saturday, Sunday, Monday and Tuesday.

On Saturday, August 26, "'Aging With a Future'—Today" will follow up podiatry's role in maintaining the momentum of the 1961 White House Conference on Aging. The program will consist of Dr. Edward L. Tarara, Mayo Clinic, "Progress with a Future," a report of the programs and recommendations of the APA Committee on Aging; Dr. Robert Giudice, Committee on Aging, APA, "Individual and Group Participation," a state survey of podiatry's contributions"; Dr. Charles R. Beber, Medical Director of the Douglas Gardens Home for the Aged, "A Look at Aging Home Podiatry Service"; and Dr. George Karelas of Newberry, Florida, "Podiatry and Organized Programs," a discussion of various state and national programs for the senior citizen.

On Sunday, August 27, the program is "Communicating in Health Education." Speakers and subjects will be: Francis A. Kalbacher, B.S., M.A., Assistant Director, APA, "The Purposes of Communicating"; Gene Nixon, Public Relations Director, Florida Medical Association, "Knowing Your Audience"; Charles Haupt, Professional Relations Director, College of Pharmacy, University of Florida, "Determining The Effectiveness of Your Communications"; and Dr. Herbert Feinberg, Co-Chairman of the Annual Meeting, 1961, "Communicating Through the Written Word." Dr. Feinberg will also give the introduction and summary of this General Session.

On Monday, August 28, Thomas M. Scotti, M.D., University of Miami, School of Medicine; and Albert Pincus, D.S.C., Medical College of Virginia, will share the spotlight with their presentation, "The Syndrome of Plantar Metatarsal Neuritis (Morton's Toe)." C. Roger Sullivan, M.D., of the Orthopaedic Surgery Section of the Mayo Clinic, Rochester, Minn., will present "Diagnosis and Treatment of Congenital Anomalies of the Feet" on the latter portion of this Monday program.

Tuesday, August 29, pediatrician Robert Schwartz will give a presentation on "Referred Pain in the Feet of Children." Also on the Tuesday program will be James V. Ganley, D.S.C., Pennhurst State Hospital for Retarded Children, speaking on "Problems of Growth and Development in the Lower Extremities."

SPECIALTY GROUPS

The American Board of Chiropodical Dermatologists and the American Society of Chiropodical Roentgenology will present concurrent two hour programs on Saturday, August 26, from 9:00 a.m. to 11:00 a.m. The ABCD program will feature James A. Conforti, D.S.C., Instructor in Mycology and Industrial Medicine, Ohio College of Chiropody, "Practical Office Mycology"; and E. William Rosenberg, M.D., Instructor in Dermatology, University of Miami School of Medicine, department of Dermatology, "Dermatologic Advances in Foot Disease." A question and answer period will follow these presentations. Dr. Conforti will conclude this program with "Dermatoses by Age Incidence," the report of a survey recently made by the ABCD. The Chiropodical Roentgenologists participating in the topic, "Stress Factors in the Foot as Seen Roentgenologically," are Joseph W. Healy, D.S.C., President of the ASCR; Ralph E. Sansone, D.S.C., Vice-president, Connecticut Podiatry Association; and James E. Bates. D.S.C., President-elect of the ASCR.

On Sunday, August 27, the American Association of Hospital Podiatrists will present their two hour program on "Hospital Podiatry." William E. Ellison, D.S.C., Chairman of the program, will introduce the three speakers, E. W. Trice, D.S.C., Vilano Beach, Florida; Sanford K. Bronstein, administrator at Cedars of Lebanon Hospital in Miami; and William S. Currie, D.O., President of the Dade County Osteopathic Association, Miami, Florida. A panel discussion will follow with Robert A. Rosen, D.S.C., Jackson Memorial Hospital, as moderator directing questions to Donald Schwartz, D.S.C., Osteopathic Hospital; Martin Horn, D.S.C., Jackson Memorial Hospital; and the three featured speakers.

The two hour program on Monday, August 28, of the American College of Foot Orthopedists consists of "The Problem of Compensatory Intoeing and its Management," Philip Brachman, D.S.C., Secretary, Council on Education, APA; "The Short Heel Cord," Richard O. Schuster, D.S.C., College Point, N. Y.; "Supernumerary Bones and Anomalies, and Their Relationship to Pathomechanical Foot Disorders," Peter N. Varzos, D.S.C., Chicago, Ill.; and "The Relationship of the Conformation of the Calcaneus to Foot Stability," Marvin J. Rubin, D.S.C., Hasbrouck Heights, N. J.

The program of the American College of Foot Surgeons, scheduled for Tuesday morning, August 29, includes four speakers, one-half hour each: C. W. Corbett, D.S.C., Sarasota, Florida, "Plantar Surgical Problems"; L. C. Midkiff, D.S.C., Secretary Oklahoma Chiropody Association, "Simple Surgical Procedures for the H. D., H. M. and Hammertoe"; Howard Johnson, D.S.C., Senior Foot Surgeon, Enid Memorial Hospital, Oklahoma City, Okla., "Elective Foot Surgery, Illustrated"; and George Y. McMahan, D.S.C., Doctors General Hospital, Fort Worth, Texas, "Neurofibroma Surgery, Illustrated."

ADDITIONAL PROGRAMS

The American Academy of Psychosomatic Podiatry will present their one hour program on Sunday, August 27. Featured speaker will be Jack T. Sanders, D.S.C., "Phychosomatic Problems Seen in the General Practice of Podiatry."

Military Podiatry will present their two hour program on Monday, August 28. Cmdr. William H. Woolf, MSC, USNR, will present "Capillary Tube Technic in Verruca Therapy." Lt. John L. Charlton, MSC, USA, and Lt. Lloyd A. Eisenberg, MSC, USAFR, will present their paper on "Clinical Approaches to Military Foot Problems" and Capt. William A. Potter, Jr., MSC, AUS, will also be on the program presenting the final report of the "Joint Army, Navy, Marine Corps Boot Evaluation Team Tests."

Papers selected from those submitted for the William J. Stickel Awards for Research in Podiatry-Chiropody for 1961 will be presented on Sunday, August 27, for one hour, and on Tuesday, August 29, for two hours.

BREAKFAST SESSIONS

Drs. Charles R. Turchin, Marvin W. Shapiro, and Bernard Egerter will be the featured speakers at the wake-up Breakfast Sessions on Saturday, August 26; Monday, August 28; and Tuesday, August 29, from 7:30 to 9:00 a.m.. You won't want to miss these informative programs based on our general theme of COMMUNICATIONS PATTERNS.

"You and Your Patient"—Do you communicate effectively with your patient regarding his foot problem?—Dr. Turchin, Saturday, August 26.

"You in Your Office"—Does the conduct and appearance of your office properly communicate your services?—Dr. Egerter, Monday, August 28.

"You with Your Community"—Does your interest in your community begin or end at the front door of your office?—Dr. Shapiro, Tuesday, August 29.

Advance registration cards for the Breakfast Sessions are to be found in this issue of the *Journal*. Attendance will be limited. Plan to attend by filling in and returning your card now.

HALL OF SCIENCE

Many scientific exhibits will be displayed for the first time at this meeting. Some of them will be: "The Clinical, Anatomical and Mechanical Evaluation of the Anterior Tibial Muscle and its Tendon," "Red Cross First Aid Anniversary, Small Craft and Water Safety," "Griseofulvin in Tinea Pedis and Onychomycosis," and a series of "Foot Health Posters" from the state of Colorado Podiatry Association. Others also included in the Hall of Science will be "Conservative Therapy of Vascular Lesions of the Lower Extremity," "New Uses of Chymotrypsin in Podiatry," "Therapeutics of Chymar Ointment," "Life's Foundation, Your Baby's Feet," "Diagnosis and Office Management of a Few Common Foot Problems," "Triamcinolone Intralesional in Podiatry," and an exhibit from the new Philadelphia College of Chiropody.

SCIENCE THEATRE

Selected films will be shown from 9:00 a.m. to 12:00 noon and from 2:00 p.m. to 5:00 p.m. The Science Theatre is arranged by the Audio-Visual Council and information sheets detailing the source of the films shown will be available at the meeting.

TECHNICAL EXHIBITS

You will enjoy touring the technical exhibits which will be open daily from 8:30 a.m. to 1:30 p.m. Experienced consultants will be available at each exhibit.

OTHER ACTIVITIES AND FUNCTIONS

HOTEL RESERVATIONS

All hotel reservations are being handled by the Americana Hotel. Advance registration cards are available in this issue of the *Journal*. Fill in and mail your advance registration card: avoid the long lines and rush at the meeting. Free folding beds are being provided in the same room with parents for children under 12. Bring your family for this "Fun in the Sun" Annual Meeting.

GENERAL INFORMATION

Headquarters Office	Conference Room 3
Press Room	Conference Room 2
Women's Headquarters	Westward Room
Youth Activities	Eastward Room
Registration and Information	Lobby

SCHEDULED SESSIONS OF THE HOUSE OF DELEGATES

Thursday, August 24	9:00 a.m. - 5:30 p.m.
Friday, August 25	9:00 a.m. - 5:30 p.m.
Sunday, August 27	2:00 p.m.

The first and second Reserve Sessions of the House of Delegates will be scheduled, if necessary, on Thursday and Friday evening beginning at 7:30 p.m.

COUNCIL AND COMMITTEE MEETINGS

Board of Trustees	August 22, 23, 29
Council on Education	August 22, 23, 24 (other sessions to be scheduled)
Credentials Committee, House of Delegates	August 24
Reference Committee, House of Delegates	August 24, 25
Budget and Fiscal Committee, House of Delegates	(To be announced)
Youth Fitness Committee	(To be announced)
State Officers Meeting	August 26

The increased interest and importance of this conference, which has, since 1958, been held in conjunction with the Annual Meeting, merits the attention of all state officers, committee chairmen, and state society staff members. Scheduled for discussion at the meeting are: Health Insurance Relations, Civil Defense, Labor Health, Legislation, Education, and Public Education and Information.

(Other Meetings To Be Announced)

ADDITIONAL MEETINGS AND FUNCTIONS

Past President's Luncheon, Saturday, August 26

Federation of Chiropody-Podiatry Boards and National Boards of Chiropody Examiners, Saturday, August 26

Podiatrists-Chiropodists in Federal Service, Saturday, August 26

American College of Foot Orthopedists Dinner Meeting, Sunday, August 27

Fund for the Advancement of Podiatry-Chiropody Education, Wednesday, August 23, 7 p.m.

American College of Foot Surgeons

Written and oral examinations, Tuesday, August 29

Meeting and luncheon, Wednesday, August 30

Advance Registration—Breakfast Sessions

7:30 A.M.-9:00 A.M.

Name _____

Address _____

COMMUNICATION PATTERNS

Sat., Aug. 26 ☐ "You with Your Patients"
Charles R. Turchin, D.S.C.

Mon., Aug. 28 ☐ "You in Your Office"
Bernard C. Egerter, D.S.C.

Tues., Aug. 29 ☐ "You and Your Community"
Marvin W. Shapiro, D.S.C.

___ Breakfast(s) $_____ (amount enclosed)

Reservations will be made on a "first come first serve" basis. One session—$5.00. Three sessions—$12.00. Send check, made payable to the APA, and registration card to:

American Podiatry Association
3301 16th St., Northwest
Washington 10, D. C.

Advance Registration
Women and Children

AMERICAN PODIATRY ASSOCIATION
NATIONAL ASSOCIATION OF CHIROPODISTS

Name _____
(Please print or type)

Address _____

City _____ State _____

☐ **Women's Program** **$12.00**
(Does not include Inaugural Banquet)

☐ **Child's Registration** ..... **$1.00 ea.** _____
(Mother of Children Must Be Registered For Women's Program)

Total _____

List children's names and ages:

_____

_____

Hotel Registration Card

49th Annual Meeting American Podiatry Assn.—National Assn. of Chiropodists
Americana Hotel, August 24-29, 1961

Please reserve the following room(s) and acknowledge to:

Name _____
(please print)

Address _____

Twin-bedded Rooms (single or double occupancy)			$12 — $14 — $16 (oceanview) $18 (oceanview with terrace)
Suites: (Parlor & one bedroom)	$38	$43	$48
Suite: (Parlor & two bedrooms)	$61	$66	

Children under 12 years of age in same room with parents FREE. Children over 12, the regular rate of $2.50 per day for an extra bed will apply; for adults, $4.00 per day for an extra bed (3rd person in room).

I expect to arrive _____ A.M. P.M. on _____

and depart _____ A.M. P.M. on _____

All reservations will be acknowledged.

Advance Registration—Member

49th ANNUAL MEETING

AMERICAN PODIATRY ASSOCIATION
NATIONAL ASSOCIATION OF CHIROPODISTS

Name _____
(Please print or type)

Address _____

City _____ State _____

☐ **Member—includes one Banquet Ticket** **$25.00**

☐ **Additional Banquet Tickets $12.00 each** ....
(Wife, Guest, A.P.S.A., Armed Services)

☐ **Member American Podiatry Students Assn.** .. **N.C.**

☐ **Member Armed Services** ..... **N.C.**

Total Amount Enclosed ..... $_____

(Advance Registration Closes August 15, 1961)

Enclose this card with your check (made out to A.P.A. Women's Program) to:

Mrs. E. B. Hurd
DuPont Building
Miami 32, Florida

Enclose this card with your check (made payable to A.P.A.) and send to:

American Podiatry Association
3301 16th St., Northwest
Washington 10, D. C.

American Podiatry Association
3301 16th St., Northwest
Washington 10, D. C.

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AMERICANA HOTEL
Oceanfront, 96th to 98th Streets
Bal Harbour
Miami Beach, Florida

Reservation Department

Alumni Luncheon of the Chicago College of Chiropody and Pedic Surgery, Sunday, August 27

American Association of Hospital Podiatrists, Monday, August 28

First Institute of Podiatry, Class of 1936, 25th Anniversary Meeting (to be scheduled)

Alumni Luncheon—Illinois College of Chiropody and Foot Surgery, Sunday, August 27

American Academy of Practice Management in Chiropody-Podiatry, Saturday, August 26

Alumni Breakfast—Ohio College of Chiropody, Sunday, August 27

(Other Meetings To Be Announced)

GOLF TOURNAMENT

The Third National Golf Tournament of the American Podiatry Association will take place Monday, August 28, 1961 at the Westview Country Club. This will be a one-day tournament with a chartered bus leaving the Americana Hotel at 8:30 a.m., taking all golfers to the course and returning before 4:00 p.m. Refreshments will be available at the Club House.

Tournament Rules: (a) The final score will be determined by the Calloway Handicap system. (b) U.S.C.G.A. Rules will govern all play unless modified by local ground rules. (c) Eligibility; all members of the A.P.A. and their wives and children over 16 years of age, also students of Podiatry Colleges and registered guests of the Convention are eligible.

Prizes: The National Trophy will be awarded for low gross score and engraved with the winner's name. The first individual to win three times will take permanent possession of the trophy. The 1958 winner was Dr. R. Zak of Cleveland, Ohio, and the 1960 winner was Dr. Anthony Galantowicz, also of Cleveland, Ohio. A first and second place trophy will be awarded in the Women's Division. The men golfers will be divided into four divisions depending on gross score: 89 and under, Division A; 90-100, Division B; 101-111, Division C; and 112 and over, Division D. The handicap will be figured and a first and second place trophy will be awarded in each division.

Special Features: (1) A special prize will be awarded for the ball closest to the pin on a short hole land also for the longest drive. (2) Calcutta Drawing tickets will be sold on each individual golfer in the tournament.

Prizes will be presented at the conclusion of tournament play at the Club House. Electric carts are available at the course and clubs may be rented. Tickets will be on sale Saturday and Sunday at the Golf Booth at the Convention at $8.00 each. For advance registration or information contact: Dr. D. F. Alexander, Central Medical Bldg., 5544 W. 25th Street, Cicero 50, Illinois; or Dr. M. Kleinman, Suite 1020 Olympia Theatre Bldg., 174 E. Flagler St., Miami 32, Florida.

SOCIAL FUNCTIONS

A free gala get-together is planned for your entertainment Friday evening, August 25, featuring the Americana Aquacade and Dixieland Band and a splash party. Plan to arrive early so that you may attend this opening function of our 49th Annual Meeting.

Saturday, August 26, is the date set for the President's Reception in the beautiful International Room. Members and guests are invited to attend this after-dinner occasion to meet the members of the official family. There will be music for dancing and awards will be presented.

Monday, August 28, is the highlight of our 1961 Annual Meeting—The Inaugural Banquet. Your registration entitles you to one ticket. Additional tickets may be reserved when you forward your member-advance-registration-card, which is in this issue of the *Journal*.

WOMEN'S PROGRAM

The Women's Auxiliary of the Florida Podiatry Association will be your official hostess. Headquarters for the ladies will be located in the Westward Room at the Americana Hotel. Your registration of $12.00 includes a sight-seeing tour to the Coconut Grove Playhouse for a buffet luncheon and matinee on Saturday from 11:30 a.m. to 5:30 p.m. and the Official Luncheon on Monday in the beautiful Bal Masque Room at the Americana Hotel. For further information contact: Mrs. Edward B. Hurd, Dupont Building, Miami, Florida.

Friday, August 25,

9:00 a.m. Registration
(Get acquainted over coffee cups in the Westward Room)
3:30 p.m. Executive Board Meeting
8:00 p.m. Water Show and Dixieland Get-Together

Saturday, August 26,

9:00 a.m. Registration
(Coffee in the Westward Room)
11:30 a.m.- Sightseeing bus trip to Coconut Grove Playhouse, buffet luncheon
5:30 p.m. and matinee
8:00 p.m. American Podiatry Association President's Reception and Ball

Sunday, August 27,

Church of your choice
9:00 a.m.- Coffee and Danish in the Westward Room
10:00 a.m.
10:00 a.m.- Opening business meeting—Westward Room
Noon
Evening Free night to go on the town
(Baby sitters available through Hotel Housekeeper)

Monday, August 28,

9:00 a.m.- Coffee and Danish in the Westward Room
10:00 a.m.
10:00 a.m.- Business Meeting, Election of Officers—Westward Room
Noon
1:00 p.m. Official Luncheon, Bal Masque Room
Honoring our National Auxiliary President, Mrs. Thelma Parham. Guests of Honor will be the President and President-Elect of the A.P.A.; guest speaker, Mr. Gordon Barrs on Floral Designing. There will be door prizes.
7:30 p.m. Annual Inaugural Banquet and Dance

Tuesday, August 29,

Departure for Europe on the BOAC Charter Flight, or for the "Caribbean Holidays" tours to the Bahamas and West Indies. Till we meet aagin.

YOUTH PROGRAM

A variety of programs for children of all ages. Remember there is no charge for extra beds for children under 12. There will be entertaining activities for the children and teen-age groups with experienced counselors assisting. $1.00 registration for each child for the entire convention. The Eastward Room will be headquarters for the Youth Activities. Youth registration of $1.00 will be taken only if mother is registered. Baby sitters available through Hotel Executive Housekeeper.

Activities such as listed below will amuse and entertain the young people while you and your wife enjoy the scientific and social functions:

Friday, August 25.

"Water Show and Dixieland Night"

Saturday, August 26

9:30 a.m. Sign up for Tournaments at Youth Headquarters
11:00 a.m.- Trip to Clyde Beatty Jungle Land. Dutch treat lunch at Clyde
4:00 p.m. Beatty's. Children of all ages may attend.
8:00 p.m. Teen-Age Blast—Indoor Pool Area

Sunday, August 27

9:00 a.m.- Church of your choice with parents
Noon Tournaments
Join your parents for sightseeing or loafing

Monday, August 28

9:00 a.m.- Tournaments, hotel and pool activities
Noon
5:00 p.m. Award Trophies for Tournaments—Floridian Room
5:30 p.m.- Weiner Roast—Floridian Room
7:00 p.m. (a minimum charge will be made for the Weiner Roast)

For additional information contact: Mrs. Fred Laubenthal, Jr., Youth Chairman, Pan American Bank Bldg., Miami, Florida.

REGISTER IN ADVANCE

MAKE YOUR HOTEL RESERVATION NOW

USE THE CARDS

PROVIDED IN THIS ISSUE

Some Questions and Answers About the National Board of Chiropody Examiners

L. A. Hansen, D.S.C.
Kansas City, Mo.

THIS is an attempt to answer some of the many questions which have been asked of me by students, colleges, state boards and other individuals in our profession. If you have any other questions that you would like answered, please send them to me.

The following are some of the questions that have been asked and the reply.

What is the Purpose of the National Board?

The National Board of Chiropody Examiners is a voluntary and unofficial examining agency, the purpose of which is to prepare and administer qualifying examinations of such high quality that legal agencies governing the practice of chiropody-podiatry within each state may, at their discretion, grant successful candidates a license without further written examination.

Do all states accept National Board certification?

It is the function of the individual states to determine who shall practice within their borders and to maintain high standards of podiatry-chiropody practice in accordance with their own rules and regulations. In recognition of the thoroughness and widely accepted standards of the National Board examinations, its certificate is accepted as a suitable qualification in lieu of examination by 19 licensing authorities in the states and Canada.

When are National Board examinations given?

The examinations are divided into two separate parts: Part I and Part II. The first examination will be given in 1962.

Where will examinations be held?

All examinations will be held at approved chiropody-podiatry schools throughout the United States.

Who is eligible?

The National Board admits to its examinations any student in, or graduate of an approved podiatry-chiropody school in the United States. A candidate is eligible for Part I who has completed the formal courses of the first 2 years in an approved school; eligibility for Part II calls for completion of a 4-year curriculum in an approved school, or any graduate from an approved school.

Upon receipt of a request initiated by a state licensing board, a specialty board, or school, an individual may be admitted to certain National Board examinations in order to satisfy any special requirements or regulations that these groups might have. In such cases, the individual is not considered a candidate for National Board certification; he is admitted to the examinations as a service to the Board or school initiating the request. The grades are, therefore, sent only to the board or school concerned.

What do Parts I and II consist of?

Part I consists of a written examination in each of the following six subjects: (1) Anatomy—Histology—Embryology, (2) Bacteriology, (3) Bio-chemistry — Chemistry — Physics, (4) Pathology, (5) Pharmacology —Materia Medica, and (6) Physiology.

Part II is a written examination in each of the following seven subjects: (1) Surgery —Anesthesia—Hospital Protocol, (2) Roentgenology — Foot pathology — Diagnosis, (3) Orthopedics—Foot gear, (4) Podiatry—Chiropody, (5) Podiatric medicine — Physical medicine—Therapeutics, (6) Jurisprudence —Ethics—Economics, and (7) Dermatology —Syphilology.

The questions in Parts I and II—all of the objective, multiple-choice type—have been devised to test not only the candidate's knowledge, but also the subtler qualities of discrimination, judgment and reasoning. Certain types of questions test the candidate's recognition of the similarity or dissimilarity of diseases, drugs, physiologic or pathologic processes. Other questions evaluate the candidate's judgment as to whether or not cause and effect relationships exist.

Case histories are used to simulate the experience of a podiatrist-chiropodist confronted with a diagnostic problem; series of questions then determine the candidate's understanding of related aspects of a case, such as associated laboratory findings, treatment, complications and prognosis. Generally each question has only one correct response among a number of possible choices —most often one out of five.

Who prepares the examinations?

Each examination is developed by a separate committee especially appointed by the National Board. Each committee is made up of about three members, including department heads, teachers and clinicians with recognized prominence in their own fields. Since 13 major subjects are included in the examinations of Parts I and II, there are 13 committees for these written examinations with a total of 39 members. These committees have wide geographic distribution. Thus, the examinations are broad in scope and reflect school teaching throughout the country.

How are the examinations prepared?

Approximately a year goes into the preparation of each examination. In the first place, each committee member thoughtfully and laboriously writes test questions, selecting that type best suited to a particular point. Each question is then subjected to the critical review of the other members of the committee and scored according to its merit. Any doubtful item is revised or discarded. Particular care is taken to avoid some point or principle that may be of special interest in one school but not generally taught or accepted in the others.

But the committee's responsibility does not end here. At the 1-day meeting, the committee reviews tentative test draft of those questions that had been agreed upon previously (through the scoring system) as being the most acceptable. Again inconsistencies or other faults are eliminated. Not until final approval is received from the committee is the examination ready for administration. Hence, each examination contains only material that has been thoroughly worked over and agreed upon as appropriate, free from ambiguity and representative not only of important aspects of a subject, but also of high standards of podiatry-chiropody education.

How are examinations graded?

When objective, multiple-choice examinations are used the work of the examiners shifts from grading the question to preparing them. Since the examiners have agreed in their committee meetings that each question has only one right answer the examinations may be graded by electric scoring machines. Lest anyone fear that his destiny is being decided by a mere machine, let us assure him that each answer sheet is scored by hand as well as by the machine. Furthermore these "robots" do not make their own decisions; they perform only in the way they are set to perform. And the final decision on whether a candidate should pass or fail is, as it has always been, in the hands of the National Board and its examiners.

A grade of 75 is established as the passing score for the individual subject, but it should not be construed that it is necessary to respond correctly to 75 per cent of the items in order to obtain this grade. The distribution curve of all those taking an examination is an important factor in arriving at the final grade.

What are some of the advantages Of National Board examinations?

The examinations of the National Board offer real benefits to candidates, to chiropody-podiatry schools, and to state boards of chiropody-podiatry examiners. Because the answer sheets are machine scorable, the grading can be accomplished rapidly, accurately and impartially. This kind of scoring also makes it possible to determine the level of difficulty of each test and to maintain comparability of scores from test to test and from year to year for any single subject. Moreover, and of even greater significance, is the facility with which the total test and individual questions can be sub-

jected to thorough and rapid statistical analyses, thus providing a sound basis for comparative studies and for the continuing improvement in the quality of the test. Because of the increased validity and reliability of these examinations, certification by the National Board has greater meaning to state licensing boards in their determination of qualification for state licensure.

Another advantage results from the fact that these examinations are set up in two parts and may be taken during the course of training in the podiatry-chiropody school when the student is fresh from his preparation in the various subjects included in the curriculum. Later, when he applies for a license to practice, he can produce evidence of his qualification in these subjects, even though his studies of many of the details may have occurred years before. This point has considerable importance in this day of change and uncertainty, when a podiatrist-chiropodist may move from one state to another and from one state licensing authority to another with an additional set of requirements for qualification. National Board certification is a permanent record which in many instances is used repeatedly in the professional career.

What about review of studies and Preparation for the Board examinations?

Students, though they might be expected to resent an additional set of examinations, are nevertheless, through it all, aware of the value of a comprehensive review of their studies. Preparing for the National Board examinations provides a stimulus to gather together knowledge they might have learned a piece at a time, and integrate it into a more whole understanding of podiatry-chiropody. The student also has the opportunity through taking National Boards to measure his own competence against that of others on a nation-wide basis.

How does one register for National Board examinations?

Candidates make application on forms provided by the National Board. Blank forms may be obtained from the dean's office of the school or directly from the office of the National Board. Registration for any examination must be completed at least 6 weeks in advance of the examination dates that are established and generally found posted in each school.—*Excerpts from the National Board Examiners, Vol. 8, No. 4. 800 Professional Bldg.*

JOHN WESLEY'S MOTTO

Do all the good you can
By all the means you can
In all the ways you can
In all the places you can
At all the times you can
To all the people you can
As long as ever you can

Pharmaceutical Preparations for the Profession

Harry L. Hoffman, Ph.G., D.S.C.
Chairman, Council on Podiatry, Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday podiatry practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Elase

Composition: Elase (fibrinolysin and desoxyribonuclease, combined (bovine), Parke-Davis) is supplied as dry material in a vial containing 25 units fibrinolysin and 15,000 units desoxyribonuclease for solution in 10 cc. of isotonic sodium chloride; and as an ointment in 30 Gm. tubes containing 30 units fibrinolysin and 20,000 units desoxyribonuclease in a special petrolatum base.

Action and Uses: Elase produces enzymatic debridement with the advantage of selectively removing fibrin and purulent exudate, leaving healthy tissue with clean surfaces to aid healing. In general topical use, aids healing in wounds, ulcers or burns on body surfaces and irrigation, in abscess cavities, hematomas, sinus tracts and fistulas, *not* to be used parenterally except in hematomas and cavities.

Administration and Dosage: Surgical, General Topical – product form and amount to use and duration of treatment are at the discretion of the doctor. For the best effect, Elase must constantly contact substrate and be reapplied at least once daily; periodically remove loosened necrotic debris. Enzymatic activity is rapidly and progressively diminished after application, especially in the solution, and probably exhausted for practical purposes after 24 hours. As packaged, dry material and ointment are stable at room temperature for 1 year. For complete details see extensive literature.

Supply: Elase–dry material for solution, in rubber-diaphragm-capped vials. Elase ointment (Oint. #79) – in 30 Gm. tubes. By Parke-Davis and Company, Detroit 32, Mich.

Domoform-HC Forte™ (pH 5.6)

Description: Creme or lotion containing 10 mg./gm. of micronized hydrocortisone alcohol and 3% iodochlorhydroxyquin in the exclusive Acid Mantle® vehicle. This exclusive vehicle potentiates the anti-inflammatory/antibacterial/antifungal actions. Restores and maintains the protective acidity of the skin and facilitates healing.

Indications: A wide range of usefulness in a great variety of eczematous and eczematoid eruptions, including infected "eczemas" in general. The higher concentration of hydrocortisone (Forte) is included to afford a more profound anti-inflammatory/antipruritic action.

Directions: Apply as directed by physician.

Supply: Creme ½ oz. tube, 1 oz. tube. Lotion ½ oz. bottle. By Dome Chemicals Inc., 125 West End Ave., New York 23, N.Y.

Caladryl Lotion and Cream
Calamine and Benadryl HCl

Composition: Light flesh-colored lotion and/or cream presenting 1% Benadryl HCl in a specially prepared calamine base.

Action and Uses: Provides effective antihistaminic and antipruritic action. Relieves skin irritations such as mild sunburn, prickly heat, the itching of hives, insect bites, mild poison oak and poison ivy and other minor skin affections.

Administration: Apply topically. Easily removed by washing.

Supply: In lotion, 6 oz. bottles and 80 cc. plastic squeeze bottles. Cream in 1½ oz. collapsible tubes. By Parke-Davis and Company, Detroit 32, Mich.

Digests From The Literature

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

DERMATOLOGY

Nylon Dermatitis, Morris, G. E. New England J. Med. 263: 30-32, 1960.

Seven cases are reported of dermatoses confined to the stocking area, or to other areas in contact with nylon. Six of these patients showed positive reactions to virgin nylon. American writers have ascribed such skin eruptions to the specific finishes or dyes of nylon, but foreign dermatologists have called virgin nylon the cause. Of 105 American dermatologists who answered a questionnaire, 12 had used virgin nylon for testing purposes, but only 5 then had it in their offices for testing.

Burning a stocking will show whether it is nylon or silk. Nylon will roll back and be odorless; silk will smell like burnt feathers and form a black bead. Microscopic examination shows a smooth, straight nylon thread; silk is wavy and irregular. Patients with suspected nylon dermatitis should be tested with virgin nylon; also, if possible, with dyes of finishes of nylon.

Griseofulvin and Dermatophycoses: International Symposium Sponsored by the University of Miami. Arch. Dermat. 81: 649-879, 1960.

The May issue of this journal is devoted entirely to discussion of this subject. A few of the articles have been abstracted to indicate its current use. In the final "Round-Table Discussion" (pp. 866-882), various physicians commented on the merits of this drug.

Callaway finds griseofulvin the most effective remedy in treatment of superficial dermatophytes. Knox had excellent results with 1 gm. given every third day in treatment of tinea capitis, good in tinea corporis, and unspectacular in tinea pedis. Newcomer noted that frequently the infection recurs on the soles of the feet, even in patients receiving 1 gm. daily for prolonged periods. Treatment of infected toenails was disappointing, some replaced themselves in 6 to 9 months, some did not grow at all, and in some patients a plateau was reached in growth, with no further improvement. Livingood had indifferent results with griseofulvin in treatment of cases of acute tinea pedis with vesicular and bulbous lesions.

A number of speakers stated that no serious reactions followed use of the drug, while a few reported casts appeared in the urine and a moderate but significant decrease in leukocyte counts. The idea is stressed that the drug should not be used unless a proved diagnosis is made of a dermatophytic infection. Both a dermalogic and mycologic diagnosis should be made. Griseofulvin is not effective in other skin diseases and may even cause a monilial overgrowth in interiginous areas (Callaway). Useless administration, moreover, can present a financial burden.

Very often drugs which seem entirely safe, after being used in many patients may prove to have undesirable effects. Use of any for the first 2 or 3 years should have follow-up blood counts at periodic intervals, if treatment has been prolonged for 6 months or more. The final results cannot be known until thousands have been treated for extended periods (Livingood).

Two additional procedures used at the UCLA School of Medicine were described by Newcomer. Before or during administration of griseofulvin, 40 per cent salicylic acid is applied to the soles of the feet. For easy application and uniform contact Luke Laboratories have incorporated the salicylic acid on a special sideways elastoplast back-

ing. Left in position for 2 days, the plaster is an effective fungicide and allows selective removal of the stratum corneum, and subsequent stimulation of epidermal proliferation. It is ideal for fungus infections on the palms and soles where the thickened stratum corneum affords a reservoir of infection. One or two applications are usually sufficient if griseofulvin is given simultaneously.

The second procedure now being experimentally studied is surgical removal of the affected nails before initiating griseofulvin therapy. The toenail and subungual keratinous debris are removed. This serves to stimulate growth and subsequent maintenance of continuing growth to total replacement. Complete growth requires 3 to 6 months instead of 6 to 12 months. The large toenails are approximately two-thirds grown at the time the other nails are completely regrown.

Short-Term Treatment of Onychomycosis with Griseofulvin, Maibach, E. I., and Kligman, A. M. Arch. Derm. 81: 733-34, 1960.

A group of 58 patients with onychomycosis of the fingernails, usually with coexistent involvement of the toenails, received 1 to 3 gm. tablets of griseofulvin in two to three divided doses after meals. Only one patient with toe onychomycosis was cured by short-term therapy. Intermittent therapy, at intervals of 2 to 3 days, failed. Whatever the course tried, there were many failures with short-term treatment.

Since all cases apparently can be cured by use of the conventional schedule of 1 gm. of griseofulvin daily, use of short-term therapy, whatever the dosage and duration of treatment, because of the many failures, does not seem justified. However, therapy not continued until the nail is completely grown out will fail.

RHEUMATIC DISEASES

The Relationship of Trauma to Arthritis, Tobin, W. J., Amer. Surgeon 25: 332-43, 1959.

In determination of the legality of insurance or compensation claims regarding the relationship of trauma to arthritis, the questions are asked: Are certain types of arthritis the result of trauma; if so, what type of injury and how severe must the injury be to bring about changes in the joint? What is the relationship between trauma and arthritis already existing? How long after the injury did the joint changes develop? In general, trauma is not considered a significant factor in development of rheumatoid arthritis, since that disease is believed to be a constitutional disturbance. Symptoms may arise in 2 to 6 months following trauma to an arthritic knee, or arthritic changes can follow trauma to a knee which is entirely normal. Whether injury has aggravated a pre-existing spondylitis is often debated in liability claims. A fracture adjacent to or involving a joint may, to some degree, cause the resulting malunion or malalignment of the joint surfaces, or lead to osteoarthritic changes. Roughening of the undersurface of the patella by fracture seems of significance in development of osteoarthritis of the knee. A posterior dislocation of the hip associated with fracture of the acetabulum may be followed by degenerative arthritis. In evaluating aggravation of a pre-existing osteoarthritis, patients often deny that any symptoms occurred prior to the accident. Clinical and roentgenologic signs usually do not develop until about 6 months after injury; they may appear within 4 weeks in severe injuries.

The changes following a traumatic arthritis resemble those of hypertrophic arthritis. However, the latter being a physiologic, degenerative process, the arthritis is probably generalized, whereas in traumatic arthritis it is localized in the joint subjected to severe injury or to repeated minor injuries. Evaluation of the extent to which injury can aggravate a pre-existing arthritis is important. Joint changes result also from abnormal stresses and strains and from advancing years, particularly in the spine. The relationship of trauma would be easy to determine if x-rays of the joint had been taken just prior to the injury.

In evaluating the aggravation of a pre-

existing arthritis the following factors must be considered: (a) Mobility, or limited range of motion due to injury; (b) stability —the intactness of the ligamentous apparatus or ligament ruptured by injury; (c) endurance—the amount of activity the joint can withstand in comparison with previous activity; (d) agility—the capacity for coordination of the joint and skill in its use compared with its former activity; (e) competing power—whether the function of the joint is limited to a point where it influences the patient's capacity to compete with others in his work; (f) strength—status of the musculature, whether recovery is complete or limited; (7) X-ray evidence of any alteration of joint surfaces.

Most arthritic patients go through cycles of freedom from symptoms. Most cases of arthritis aggravated by trauma have leveling-off periods of one to one and one-half years. As a rule the arthritic process is a slowly progressive one, with or without trauma as an aggravating factor.

Common Granulomatous Inflammations of the Extremities, Kirkpatrick, J. E. California Med. 92: 147-49, 1960.

Symptoms of granulomatous inflammation are too frequently ascribed to trauma, particularly to insignificant bruises or to some imagined slight trauma. This disease is never produced by trauma. It may be caused by such agents as bacteria or coccidia; by silica, fats and oils; by collagen, cholesterol, uric acid; by the rheumatoid factor, by Bence-Jones protein. Possibly it is due to some unknown agent in Hodgson's disease, rheumatic fever, mycosis fungoides, or sarcoid of Boeck.

Numerous conditions have been cited as due to trauma: xanthoma of tendons actually produced by a hypercholesteremic familial metabolic disorder; spontaneous rupture of tendons in their osseofibrous tunnels resulting from rheumatoid arthritis; peripheral median nerve neuritis due to tenosynovitis of the tendons in the tunnels; De Quervain's disease; nonosteogenic fibroma of bone, or Heberden's nodes.

Common types of disease affecting the extremities—fibrositis, myositis bursitis—may run their course without treatment, and some effects of the disease may be reversible without therapy; some may recur at intervals, or may become chronic. However the granulomatous inflammations and rheumatic disorders mentioned have never been proved due to mechanical trauma. These diseases are associated with dysfunction of the reticuloendothelial system, and trauma does not produce a persistent stimulative effect on the cells of that system. The course of granulomatous inflammation is toward chronicity and recurrence. These lesions may be reversible, may end in scarring, or may cause total progressive dissolution of tissue or lead to death of the individual.

If a patient claims his condition is due to trauma, the physician, instead of using pathologic reasoning, may agree in order to avoid conflict with the patient, the labor union, or the patient's employer. Now that employees are increasingly covered by insurance, fewer young physicians will be exposed to such a concept, as payment for services will not be dependent upon whether or not the condition is certified as being connected with the job. When a patient attributes a disorder of the extremities to a trauma incurred in his work, the physician does him a worth-while service if on examination he diagnoses a granulomatous disease and explains the true nature of the patient's disorder.

Analgesics in Rheumatic Disorders, Hart, F. D. British Med. J. 1: 1265-66, 1960.

No cure for rheumatic disease is known. Patients should live in harmony with the disorder, taking analgesic drugs for relief of pain, and have proper exercise and rest. Habit forming drugs should not be taken routinely. Some drugs, quite effective as analgesics, may cause gastrointestinal irritation. Therapy must be tailored to the individual, with careful instructions regarding use at certain times a day, depending upon the intensity of symptoms. Aspirin (acetylsalicylic acid), the mainstay in

chronic articular disease, in doses of 10 to 15 gr., preferably with food or milk, and preferably crushed, is analgesic and antipyrectic. Easily absorbed, its effects are felt within 10 to 15 minutes and last from 2 to 4 hours. It is quickly excreted through the kidneys. Aspirin is not tolerated by some patients, but usually no ill effects are felt. The drug is best taken in the morning and at bedtime. The average arthritic patient takes 8 to 12 tablets a day (40-60 gr.), sometimes more. Side effects can be allergy and rash, slight prolongation of prothrombin time of the blood and, in severe cases of liver damage, hemorrhage.

Various compounds of acetylsalicylic acid in tablets and mixtures are used; tablet form is preferable to liquid. An aspirin-opium mixture (15 to 20 gr. acetylsalicylic acid with 10 minims of tinct. opii) is of great help in cases of severe pain. The commonly used mixture is acetylsalicylic acid 3½ gr. (230 mg.) and phenacetin 2½ gr. (160 mg.), but the latter ingredient may cause methemoglobinemia and severe renal damage. The buffered form of aspirin does not insure prevention of dyspepsia.

Amidopyrine carries the risk of agranulocytosis and is not recommended. *Codeine phosphate* in small amounts in compound aspirin tablets (4 gr. each of aspirin and phenacetin and 1/8 gr. (8 mg.) codeine phosphate) is too constipating for some patients. Others find them superior to aspirin. *Sodium salicylate* (20 gr. every 2 or 3 hours) is used only for acute rheumatic fever and is less effective than aspirin.

MISCELLANEOUS

A Definition of Chiropody, Svoboda, N. F. Nebraska State J. M. 44: 150, 173, 1959.

Chiropody, derived from two Greek words: *cheiro* (hand) and pod (foot), first used in 1768, originally meant treatment of diseases of the hand and feet, but later referred only to treatment of foot diseases. For that reason the more suitable word "podiatry" came into use in the United States, and recently the National Association of Chiropody became the American Podiatry Association. The Department of Health, Education and Welfare of United States defines podiatry as a specialty of medicine and surgery (an ancillary profession) concerned with care of the human foot in health and disease—prevention, diagnosis and treatment of foot disorders by mechanical, physical and surgical methods, except amputation of the foot, and including non-surgical treatment of the muscles and tendons of the leg governing the functions of the foot.

Beginning with the founding of the pediatric society of New York in 1895, and recognized by the New York State legislature, every state now controls licensing of chiropodists. The Illinois College of Chiropody and Foot Surgery, and the College of Podiatry of Long Island were each founded in 1912 to teach basic principles of medicine and surgery of the foot. The United States now has six recognized colleges with an enrollment of 1,200 students; 200 to 400 Doctors of Podiatry are graduated annually.

Applicants for entrance must have had two years of medical education. To obtain the degree of Doctor of Surgical Chiropody requires an additional four years at one of the recognized colleges. The hours required are from 32 to 36 weeks per year, with a total of 4,100 to 4,300 hours in the four-year course—with 540 hours of clinical work during each of the last three years. Fifty per cent of the faculty have an M.D. degree. The departments of physiology, physiotherapy, roentgenology, pathology, dermatology, neurology, and chiropodal medicine and surgery must be headed by an M.D. Chiropodists may head the remaining departments.

The colleges all have carefully supervised clinics, open to the public, and all provide elective clinical postgraduate internships to meet the practice laws of some states, including didactic and clinical training in surgery, orthopedics, pediatrics, geriatrics, and roentgenology. No degree is granted for these courses.

Organization News

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

Alabama

At the annual meeting of the Alabama Association of Podiatrists-Chiropodists held in Montgomery, the following officers were elected: President, C. H. Crowley of Mobile; Vice President, E. J. Favenesi of Florence; Secretary-Treasurer, Edward E. Sealy of Montgomery; Delegate, E. J. Favenesi and Alternate, Edward E. Sealy.

California

The Region 12 meeting was held at the Jack Tar Hotel in San Francisco, May 24-27, 1961. An outstanding scientific program featured Laurence Rivkin, M.D., of the University of California Medical School, who spoke on "Closed Cardian Compression." The meeting of the Western Division of the American College of Foot Surgeons was held May 28th.

The following officers were elected: President, George A. Shore of Lynwood; President-elect, Robert S. Nichols; Vice President, Julian Segal; Secretary-Treasurer, Robert O. Johns. Delegates to the 1961 A.P.A. annual meeting will be Drs. Robert L. Jacoby, Robert O. Johns, George A. Shore and Robert S. Nichols. Alternates will be Drs. Anthony J. DeLeo, William F. Eads and Edward Tornow.

The Flamingo Hotel in Las Vegas was selected as the site of the 1962 Western Podiatry Congress.

Illinois

A proclamation for Foot Health Week, issued by Lester E. Collins, Mayor of Springfield, Illinois, was presented to Dr. Fred G. Broun, President of the Illinois Podiatry Society. The presentation was made on May 10th by Frederick S. O'Hara, Commissioner of Public Health (representing the Mayor) at a luncheon held at the Abraham Lincoln Hotel for members of the Sangamon County Podiatry Society.

Other Foot Health Week activities included presentation by Drs. C. Young and R. Winston of "The Winged Foot" to The

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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American Practical Home Nursing Association at the Y.W.C.A., followed by a talk by Dr. Robert Parker and a question and answer session; an address by Dr. P. F. Mahaffey on "Feet With A Future," delivered to The Frontiers of America, a businessman's civic club, and presentation of "The Winged Foot" to the club.

Kansas

The Kansas Podiatry Association has established an executive secretary's office in Topeka, Kansas. At its regular spring meeting in Great Bend, Kansas, the association elected to retain Wayne Probasco, Attorney at Law, to serve as Executive Secretary. Mr. Probasco recently assisted the association in eliminating some insurance problems. He will also serve on the Intra-Professional Advisory Council. Other duties will include legislative matters, creating a newsletter and public education-relations program.

Speakers at the May meeting were: John Thurlon, M.D., orthopedic surgeon, of Hays, Kansas, on "Podopediatrics," F. S. Garlock, M.D., anesthesiologist, "Emergencies and External Cardiac Massage," D. Mahrle, D.S.C., "Plaster of Paris Management of Congenital Foot Deformities."

Kansas podiatrists will participate in the state Civilian Defense program. The Intra-Professional Advisory Council recently approved the Kansas Podiatry Association for admission to the council.

The Kansas Podiatry Association exhibited the A.P.A. Medical-Hospital exhibit booth at the recent Mid-West Hospital Association Convention in Kansas City, with more than 2,400 delegates attending. Plans are to exhibit next year, making the booth a joint state project for interested states.

Louisiana

At the May meeting of the Louisiana State Chiropodists' Association, the following officers were elected: President, Wayne Taggart of Shreveport; Vice President, R. J. Ducote of Baton Rouge; Secretary-Treasurer, Donald Zichichi of New Orleans was re-elected.

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*McGregor—Journal of the American Podiatry Association; July, 1961.

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Pennsylvania

Lehigh Valley Podiatry Society

At the May 21 meeting of the Lehigh Valley Podiatry Society, Dr. Raymond Locke spoke on "New Trend in Steroid Therapy in Foot Problems." Plans are being made for the annual closing affair to be held at the Indian Valley Country Club.

Northwestern Division

The Northwestern Division of the Chiropody Society of Pennsylvania met on May 21 in Sharon. Appearing on the scientific program was Dr. Phil Davidson of Youngstown, who presented slides, case histories and treatment of routine foot problems seen in his office. Dr. Davidson discussed the greater freedom in scientific treatment of foot problems permitted in Ohio as compared to that under existing laws in Pennsylvania.

The following officers were elected: President, Richard Wagner; Vice President, John Ziegler; Secretary, John Pankratz; Treasurer, Leo Lacey; Delegates, Chester Rossi and Quinton Crawford; Alternates, Richard Wagner and John Ziegler and Parliamentarian, Donald Steines.

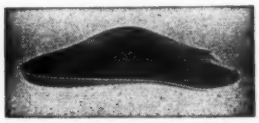
The membership voted to accept a division group insurance program with Chester Rossi serving as president.

The next meeting will be held in New Castle. A scientific program on "Diagnosis" will be presented by Ralph H. Orr.

Greater Philadelphia Chiropody Society

Dr. Jay Vizer, Director of Professional and Public Information of the Greater Philadelphia Chiropody Society has requested that members of the American Podiatry Association cooperate with the Hospital of the University of Pennsylvania in their research on fungus growth in epidermal tissue, providing debrised callus tissue for use in this research. This project has been given the title "Operation Venice" referring to the "Merchant of Venice" in supplying a pound of flesh without blood. The laboratory direction and

THE HOUSE OF COMFORT



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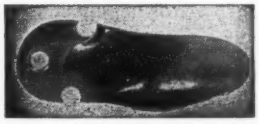

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technical research is being supervised by Dr. Albert Kligman, eminent in the field of allergy and dermatology.

Procedure to follow has been simplified to avoid interference with normal office routine. Collect all callus tissues acquired from each patient given this type of treatment. The collected tissue is stored in a pint plastic container or similar receptacle. When full, the container should be shipped to Dr. Vizer, 54th Street Centre Building, Philadelphia 31, Pennsylvania, for eventual transfer to the hospital. The collected materials should be clean and free of antiseptic swabs or other foreign matter. The only restriction is that the patient must not be under any medication, local or systemic, for control of a fungus infection.

Virginia

The Podiatry Society of Virginia held its annual meeting on May 6, 7, 1961 in Alexandria, Virginia. Dr. Richard Schuster of College Point, N. Y., guest lecturer, presented "Orthopedics, Examination and

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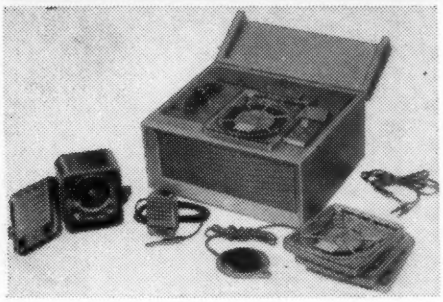

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Diagnosis."

The following officers were elected: President, Herman Chapel of Norfolk; Vice President, Leonard L. Cramer of Norfolk; Secretary-Treasurer, I. Leonard Kaplan of Portsmouth; Member at Large Executive Board, Carl Checknoff of Falls Church.

After dinner speaker was Mr. G. R. Rodericks, Director of Civil Defense, Washington, D. C., whose timely topic tied in with the society's number one project, Civil Defense.

A.C.F.O.

The Tenth Anniversary Dinner meeting of the American College of Foot Orthopedists will be held on Sunday, August 27th, at the Hotel Americans. All members should be present to honor our past presidents. This important meeting will concern itself with the Postgraduate Course, the Point System to maintain membership and other pertinent constitutional amendments.

"Weekend in Washington"

Region Eight

[*Va., W.Va., N.C., S.C., D.C.*]

American Podiatry Association

November 10-11-12, 1961

Shoreham Hotel, Washington, D. C.

The testimonial Banquet will be given in honor of Dr. Albert Pincus, Richmond, Virginia, for his contributions to the advancement of Podiatry. A cordial invitation is extended to all his friends to attend and honor Dr. Pincus.

Women's Auxiliary
American Podiatry Association
Annual Report
1960-1961

The Women's Auxiliary of the American Podiatry Association, being fully aware of the fact that we are an affiliated organization of the American Podiatry Association, has made every effort this past year to work closely with the members of the A.P.A. and to keep the Washington office informed of our activities.

Our membership for the past year stands at 844. Three new auxiliaries from Rhode Island, Georgia and Oregon, have been organized this past year. A membership kit to aid in the organization of new auxiliaries and to be of assistance to those already in existence was compiled by our membership chairman, Mrs. Fred G. Broun of Chicago. It is available upon request.

Our foremost project continues to be our booklet, "Life's Foundation—Your Baby's Feet." As of May 10, 1961, 261,525 copies of this booklet have been distributed. We are grateful to the members of the A.P.A. for their acceptance and use of this booklet.

The President of the Women's Auxiliary is a member of the Board of Trustees for the Fund for the Advancement of Podiatry-Chiropody Education. This past year, the Auxiliary made a contribution of $600.00 to the Fund. A contribution of $100.00 was made to the Foot Exhibit for the Science and Industry Building in Chicago. We have established a Philanthropic Fund within our organization and through this fund, we hope to be able to make additional contributions to the above-named very worthwhile organizations. Mrs. Bruce Wright of Battle Creek, Michigan, is in charge of this project.

Our convention chairman, Mrs. Edward Hurd of Miami, Florida, has worked very closely with Dr. Nyman in formulating the plans for the A.P.A. convention for 1961 in Miami Beach.

An Auxiliary Message has appeared in each issue of the Journal of the American Podiatry Association and in addition to

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this, three issues of the Auxiliary Bulletin have been sent to each member. Mrs. Robert Shor of Los Angeles, California, is the Bulletin Editor. Through these two mediums, we attempt to keep the podiatrists and their wives informed on Auxiliary activities.

It was the President's pleasure to attend the Region I meeting in Hartford, Connecticut, on October, 1960, and to be able to talk with the ladies at that meeting. One Auxiliary has been organized as a result of that visit and we hope that others in the Region will soon become affiliated with the National.

Our members are active on a local basis in their own cities – in civic clubs, PTA organizations, church activities and many as hospital volunteer workers. It is through the various local organizations in which we work that we are able to be public relations workers for the profession of podiatry-chiropody.

Mrs. Cleotha Parham, President

Women's Auxiliary Message

In a short time, we will all be gathering in Miami Beach for the 1961 A.P.A. Convention.

We are expecting YOU and your family to attend. While you, Doctor, are gaining knowledge about your profession, we members of the Women's Auxiliary will see that your wife and your family are well entertained. A special program is being planned for the children and young adults.

COME EARLY AND STAY LATE and let's all have FUN in Miami.

Be seein' you.

Mrs. Cleotha Parham, President

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Deaths Reported

Fred Buford
Washington, D. C.

Dr. Fred Buford died of cancer at the age of 76, at his home, 1134 Q Street, N. W. He studied podiatry at the First Institute of Podiatry in New York and started practice after his retirement from the Government Printing Office in 1933.

He is survived by his wife, two daughters and a son.

Robert H. Collins
Glens Falls, N. Y.

Carl O. Dehmel
Berkeley, Calif.

Dr. Dehmel, retired San Francisco podiatrist, died on May 31, 1961 at the age of 91, while visiting his son in Short Hills, N. J. He was one of the first graduates of the California School of Chiropody and practiced in San Francisco until his retirement in May 1952. He was a Life Member of the California Podiatry Association and the American Podiatry Association.

Surviving are his wife, Katherine, his son, Richard, and two grandchildren.

Douglas D. Dodson
Santa Paula, Calif.

Dr. Dodson, 39, of Santa Paula, California, died April 30, 1961 of a heart attack in his car in front of his office. He was a graduate of the California Podiatry College, class of '49. He served as Secretary of the Tri-Counties Division of the California Podiatry Association this past year.

Surviving are his wife, Coleen, a daughter, DeDe, 8, and a son, Danny, 11.

Miss Ann Marie Fox
Chicago, Ill.

Miss Fox, former executive secretary of the Illinois Podiatry Society, passed away June 2 in Chicago. At the time of her death, Miss Fox was operating her own free lance public relations agency.

Myron Keller
Providence, R. I.

Harold C. Winckelbach
Indianapolis, Ind.

Pearl Young
Buffalo, N. Y.

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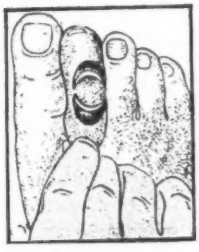

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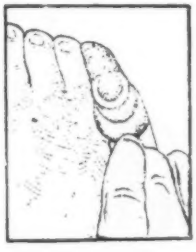

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Dates to Remember

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MEETINGS

American Podiatry Association

Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel

Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One

(Conn., Maine, Mass., N. H., R. I., Vt.)
Chicopee, Mass., Oct. 14-16, 1961
Schine Inn

Dr. A. Joseph O'Rourke, Gen. Mgr.
176 Academy Ave., Providence, R. I.

Region Two

(New York)

Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three

(Del., Md., N. J., Pa.)

Region Four

(Ohio)

J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five

(Ill., Ind., Mich., Wis.)

Region Six

(Colo., Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Minneapolis, Minn., May 4-6, 1962
Leamington Hotel

Dr. W. J. Olson
322 Midland Bldg., St. Paul, Minn.

Region Seven

(Idaho, Mont., Ore., Wash., Wyo.)

Region Eight

(D. C., N. C., S. C., Va., W. Va.)
Washington, D. C., Nov. 10-12, 1961
Shoreham Hotel

Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine

(Florida)

Joy E. Adams
401 Florida Natl. Bank Bldg.
St. Petersburg, Fla.

Region Ten

(Ala., Ga., Ky., Miss., Tenn.)
Birmingham, Ala., Oct. 20-22, 1961
Bankhead Hotel

Dr. Stanley Frank, Secretary
1250 Forrest Ave.
Gadsden, Ala.

Region Eleven

(Ark., La., N. Mex., Okla., Texas)
Dallas, Texas, June 21-23, 1962
Sheraton Hotel

Mr. C. J. M. Roesch, Ex. Sec.
Chiropody Society of Texas
407 Austin Savings Bldg., Austin, Texas

Region Twelve

(Ariz., Cal., Nev., Utah)

International Union of Podology

Second International Congress.
Belgium, France, W. Germany, Holland, Spain, Switzerland, Argentina, Sept. 8-12, 1961.

Canadian Podiatry Association

Vancouver, B. C., Aug. 18-20, 1961
University of B. C.

Dr. N. Mathews, Chairman
624 - 6th St., New Westminster, B. C., Canada

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

Zaccharian Research Society

The Zaccharian Research Society, at its recent senior banquet held at the Park Lane Villa, was addressed by Drs. Max Pomerantz, Bernhardt Egerter and Thomas Fletcher. Among the outgoing seniors were Burton Davis, Jack Levine, Olive Foster, Victor Sabeth, Howard Mitchell and Gerald Besterman. Six sophomores at the Ohio College of Chiropody were initiated.

Various views on research were presented and the society is now considering projects from companies concerned with drugs used in chiropody and original chiropodical research.

Rehabilitation Nursing Course

Dr. Edward Tornow presented a lecture on "Prevention and Treatment of Common Foot Disorders" and "The Care of the Foot of the Aged Patient in the Nursing Home," during a 5-day course offering a broad view of the principles, procedures and problems involved in rehabilitation nursing of patients in nursing homes and the techniques of training and supervising nursing home personnel in rehabilitation nursing procedures. All sessions were held in the Ben R. Meyer Rehabilitation Center of Cedars of Lebanon Hospital, Los Angeles, California, May 22-26 and June 12-16, 1961.

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